INCREASE IN THE MEDICARE PART B PREMIUM FOR 1989

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

SEPTEMBER 29, 1988

Serial 100-90

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
92-682 WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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CONTENTS

Page

Press release of Monday, September 19, 1989, announcing the hearing 2

WITNESSES

U.S. Department of Health and Human Services, William L. Roper, M.D., Administrator, Health Care Financing Administration 6

Physician Payment Review Commission, Philip R. Lee, M.D., Chairman, and Paul B. Ginsburg, Executive Director 33

American Medical Association, James S. Todd, M.D., Bruce Blehart, and Janet Horan 59

Center for Health Economics Research, Janet B. Mitchell 53

SUBMISSIONS FOR THE RECORD

Annunzio, Hon. Frank, a Representative in Congress from the State of Illinois, statement 83

Frankl, William S., M.D., Hahnemann University, Department of Medicine, Division of Cardiology, Philadelphia, PA 84

National Committee To Preserve Social Security and Medicare, Hon. James Roosevelt, statement 86

INCREASE IN THE MEDICARE PART B PREMIUM FOR 1989

THURSDAY, SEPTEMBER 29, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:05 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, SEPTEMBER 19, 1988

PRESS RELEASE #26
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE INCREASE IN THE MEDICARE PART B PREMIUM FOR 1989, TO BE HELD ON THURSDAY, SEPTEMBER 29, 1988

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the increase in the Medicare Part B premium for 1989. The hearing will be held on Thursday, September 29, 1988, beginning at 2:00 p.m. in the Main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "Recent increases in the premiums the elderly pay for Medicare highlight the need to get program costs under control.

"Total payments to physicians have been increasing at an average rate of 15 percent a year since 1975. Costs are increasing much faster than can be explained by the aging of our population. Price inflation explains only a small portion of the increase in costs. Most of the increase is due to rapid increases in the volume of services provided on a per beneficiary basis.

"This year, cost increases have slowed slightly to 12 percent. Yet even at this rate, total program costs will double in another six years. We cannot continue to pass these increases on to the elderly or to the taxpayers. Costs can be controlled without risk to quality.

"The fundamental problem is that Medicare gives doctors a blank check. The more services they provide, the more they earn, whether or not the services are really needed. Medicare generally pays the bill with no questions asked. With nearly 400 million claims a year to process, utilization review can only provide limited protection against the most flagrant abuses.

"One thing is clear. Any serious proposal for physician payment reform under Medicare must deal squarely with the problem of rapidly increasing volume, otherwise the spiral of costs will continue and Congress will be forced by budgetary pressures to respond with a new round of freezes and cuts."

The hearing will include testimony from Dr. William L. Roper, Administrator, Health Care Financing Administration, Department of Health and Human Services; Dr. Philip R. Lee, Chairman of the Physician Payment Review Commission; and a representative of the American Medical Association.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

(MORE)

BACKGROUND:

Medicare Part B is an insurance program for the elderly and disabled which covers physician services, outpatient hospital care, and a variety of other ambulatory services. Benefit payments are expected to total $34 billion in fiscal year 1988. Physician services account for 72 percent of the total.

A major portion of program costs are met by premiums paid by beneficiaries. Since 1984, premiums have been set each year at a level sufficient to cover 25-percent of projected program costs. The 25-percent rule will lapse at the end of 1989. Thereafter, premiums will be increased each year by the Social Security cost-of-living adjustment (COLA) increase.

The 1988 premium is $24.80 a month. The 1989 premium, which will be officially announced by HCFA on September 30, 1988, is expected to increase by about $3.00, or 12 percent, compared with an estimated 4.1-percent increase in Social Security checks. A separate increase of $4.00 a month will be made to pay for new benefits added by the Medicare Catastrophic Coverage Act of 1988.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, October 14, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman **Stark**. The Health Subcommittee of the Committee on Ways and Means will begin a hearing on the Medicare part B premium for 1989, and the related issue of expenditure growth under the Medicare part B.

If I knew what the full name of HCFA was, I would say it in deference to its distinguished Director, who is here, but HCFA will announce an increase in the premium of $3.10 from $24.80 a month to $27.90 a month.

And there will be a separate $4 add-on to cover the cost of the new benefits provided by the Catastrophic Coverage Act.

The $3.10 increase is driven primarily by continued rapid growth in payments for physicians' services.

Over a 10-year period, payments for physician services have increased at an average rate of 15 percent a year. With our shoes and socks on, we know this means they double every 5 years. This year, the increase has slowed somewhat, to 12 percent, but even at this rate, total payments will double in 6 years.

More than 50 percent of the cost increase is due to increases in the volume of care. Only 20 percent is due to enrollment and aging. The remainder is due to the annual inflation update in prices.

I do not think that the taxpayers are going to continue to allow us to pass these increases on to the elderly, or to them, and including those elderly who happen to be taxpayers. Costs, we think, can be controlled without risk to quality.

It seems to me to say otherwise, is to lay a smoke screen against negotiations for a reasonable solution.

The fundamental problem is that Medicare pays physicians with a blank check. The more services that are provided, the more earnings they receive, whether or not the services are really needed. With nearly 400 million claims a year to process, utilization review can provide only limited protection against the most flagrant abuses.

Yesterday, HCFA released the Harvard relative value scale study. This is the first objective study of the relative work involved in providing physician services, and it raises questions about equity across specialties.

But equity is just one of the factors that Congress must consider if we develop a new payment system for Medicare. The principal problem is to keep health care affordable for the elderly and the taxpayers.

This means we have to contain the aggregate cost of what is going out. To set fees is only part of the issue. We can cut a fee from $10 to $5 and bill three times as many fees. If you just raise it to $15 that gets us nowhere.

There is a very real danger, in what we will refer to today as the Hsiao study, that people will look at this as a payment system. It is not. It does not begin to become a payment system. I would liken it to the old flat-rate manuals we used to use when we worked on Fords, back in 1935. It was a manual that said you have so many hours for changing a transmission or cleaning a carburetor. Those are terms more familiar to me than some used in the medical profession.

It does not suggest how much you paid per hour, and, as I understand the Hsiao study, it merely makes a relative distinction between the worth, if you will, of some 3,000 procedures.

What we do with that could be great. We could, if the Chair had his way, use it to set salaries for doctors, and put all doctors who provide Medicare on salary. I think we would get a lot better medical care. But I do not think I have the votes.

We could use it to bid from a community, or a group practice for so many units of medical care a year, and we would purchase those units from the lowest-cost group, and then we would distribute those units within the group in whatever way is needed.

We could go to capitation. We could go to the preferred provider plan. In all of those instances I think the Hsiao study, if it survives the professional scrutiny of the peer review that the professional community will give it, can be a very useful tool in having a fair plan from the standpoint of the specialists. For that, I think Dr. Hsiao and Harvard University are to be commended.

But we must look at a variety of options. Capitation for a provider, and mandated fee schedules.

The administration, Congress, and enlightened physicians should work together, hopefully to slow the rate of cost increase in an equitable manner.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Clearly, the numbers that will be presented to us today are better than last year. Also, clearly, they are not good enough. In my mind, they add weight to the argument that this committee, working closely with the administration, and with health-care providers, should be considering fundamental reform of the payment mechanisms in part B.

We certainly are on the way to doing that, and as I see it, this continuing, very rapid increase in the price of these services, will just be an added pressure on us to move promptly in that direction.

Thank you, Mr. Chairman.

Chairman **Stark**. Thank you. I think I would like to, by way of introduction of our first witness, Dr. William Roper, the Administrator of the Health Care Financing Administration, mention that at least in the 100th Congress, this may very well be the last chance we will have you with the committee, Dr. Roper.

I want to say how much we appreciate your work with the committee over the past 2 years that you have served as the Administrator of HCFA.

I have been dealing with Health and Human Services and HEW, both chairing the Welfare Committee and this subcommittee for a number of years, and rarely have we dealt, in the Chair's opinion, with a bureaucrat—and I say that in the highest laudatory way—who has been as helpful, tough, fair, and forthcoming. It has been a joy to work with you.

When I see you next, I hope it is in another capacity, but I look forward to seeing you again soon, and thank you.

Now please proceed to enlighten us in any manner you care to.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. Roper. Your comments are very kind, Mr. Chairman, and my regard for you and the committee are equally high. I appreciate the opportunity I have had to work with you.

As you say in your opening statement, we are here to talk about the part B premium under Medicare, and other issues surrounding physician payment under the program.

I will summarize my statement.

The notice that we are publishing tomorrow in the Federal Register states that the part B premium for 1989 will be $27.90 a month. That reflects an increase of $3.10, or 12.5 percent over the current premium of $24.80.

Last year, when I appeared before the committee, I had to report to you that the premium would be increased $6.90, or 38.5 percent.

So the news is much better this year, only a third as much of an increase, but it is still [illegible] troublesome increase.

Also this year, we are announcing the implementation of the new Medicare Catastrophic Coverage Act which requires a premium of $4 per month for the first year. This act provides a major improvement in services and coverage for Medicare beneficiaries.

So there will be a $3.10 increase in the general premium, and $4.00 for catastrophic. There are some beneficiaries, a little fewer than a million, who will not be required to pay the full increase in the part B premium and the catastrophic premium because of the provision in law that says no one shall have his or her Social Security check reduced as a result of premium increases.

In addition, the Medicare Catastrophic Coverage Act requires Medicaid to pay Medicare premiums for low-income beneficiaries. Those below the poverty line will be completely protected.

Let me address specifically the question of the increase in the part B premium. This $27.90 for next year is one quarter of our estimate of part B expenditures for the aged beneficiaries in the Medicare program.

The requirement that the premium be at a quarter of the cost to the program is an important one. We believe there are sound public policy reasons for continuing that 25 percent relationship into the future, and we will continue to argue for that to be made permanent.

The $3.10 increase in the premium is made up of four components. Projected spending increases under the program, from this year to next year, account for $2.90, or 11.7 percentage points of the 12.5 percent increase. So most of it is just that more money is being spent.

The second component of the increase is a correction for last year's projection. We increased the premium significantly last year because of our projection of increased spending. Spending did not go up quite as much.

A significant reason for that is the steps that both you and the Department took together in OBRA 1987 to put in place a number of changes; for example, freezing fees for all except primary care and reducing payments for certain procedures. Those are important steps but they are transitory steps, and I would not want anyone to turn away from an effort to find a permanent solution to the problem. But it did improve things.

A third component of the premium increase is the contingency margin. Our actuaries believe we need to set aside some funds to make sure that we have an adequate cushion for increases that might occur in the future.

And the fourth part of the premium increase is interest income. We have earned some interest on the balance in the trust fund and that holds down the premium increase.

Chairman **Stark**. Could I?

Dr. **Roper**. Yes, sir. Please do.

Chairman **Stark**. I am trying to remember. As I recall, last year, $3 or $4 of the $6.90 increase was used to replenish the contingency fund, because in previous years we had knowingly held down the increase and used up contingency funds——

Dr. **Roper**. Last year the contingency reserve was $1.50 or 22 percent of the $6.90 premium increase.

Chairman **Stark**. So of the $6.90 increase last year, almost half, I thought, was used to rebuild the contingency fund. Now, this year, it looks like we are putting in another $1.50, or a third.

Is that because we did not build the contingency fund enough last year?

Dr. **Roper**. Right.

Chairman **Stark**. I thought we made the entire thing whole last year with——

Dr. **Roper**. No. In view of all the other things that were going on last year, we only partially replenished the contingency, and we need to go——

Chairman **Stark**. But we could?

Dr. **Roper**. We could have.

Chairman **Stark**. And this year we could, then, in a sense—if we wanted to—hold it down by $1.15. Wait a minute.

Yes. We would not be robbing anyone, except we would be getting closer—and there is the risk that we would have to increase it more in the future.

So with the increase of $3.10, we really have $1.15 in there that is not needed, save our estimate of a contingency fund?

Dr. **Roper**. Yes, but I would press that there are very important reasons for having a contingency.

Chairman **Stark**. OK. That is obvious, or we would not have it.

Dr. **Roper**. Yes.

Chairman **Stark**. I would just like to point out that we have, in the past, with similar sets of circumstances, passed over raising it as much—for whatever reasons I do not recall—but we made decisions in past years to not raise it as much. Thank you.

Dr. **Roper**. Sure.

Let me talk for a few minutes about physician and part B spending in general in the Medicare program.

Physician services represent the largest share of part B services. About 60 percent of the dollars we spend are for physician services. Total Medicare spending on physician services is large, and it is growing rapidly. For fiscal year 1990, we estimate it will be about $27 billion, 2 percent of the entire Federal budget.

The growth rate has been a historic one of 13–15 percent per year. An important point to make is that the growth rate between 1986 and 1987 for physician services was about 18 percent.

For inpatient hospital services it was about 4 percent, so there is a significant difference in the growth rates of these two parts of the Medicare program.

We expect double-digit increases in the part B program's outlays over the longer term, such that total Medicare expenditures will exceed total Social Security expenditures by the year 2005.

That is a point that my successor will be able to point to with some surprise, I suppose, in running the largest entitlement program in the Government. Medicare is going to be larger than Social Security right after the turn of the century, unless events change.

The increase in outlays has been driven predominantly by increases in volume and intensity of services. New services, technology, are a part of the calculation. In total, the volume and intensity figure represents about one-half of the overall increase.

We funded a number of research studies to look at the cause of these increases.

One of the researchers who has looked carefully at this, Dr. Janet Mitchell, is going to be testifying shortly. We, as much as anybody else, would like to have much more complete explanations for these phenomena. We are looking at them but do not have, complete answers as yet.

Much of the increase in the volume of physician services provides real benefit for patients. They are better off because of it and we are glad for that.

But there is some unnecessary utilization of services, and that is the reason behind our effectiveness initiative: our desire to use our resources to develop better information on what works in the practice of medicine.

As I pointed out to you yesterday, the current issue of Fortune magazine has an article—and I have given you copies of it—entitled "Medical Care's Next Revolution," and that is something that I hope everybody focuses a lot of attention on in the future.

Now I would like to discuss where we ought to be headed in Medicare physician payment. Yesterday, we presented the Harvard study on a fee schedule based on a relative value scale. That is an important contribution to our knowledge.

The study has been widely reported in today's newspapers. I will not dwell on the details except to say what I said to you in private yesterday, and at a press conference later—exchanging one fee-for-service payment system for another does not solve all of the problems we have. It surely does not treat the question of increased volume and intensity of services.

To be fair, a relative value scale-based fee schedule would send better signals to doctors about which things we wanted to encourage in the Medicare program; but on its own, it should not be seen as a magic bullet that is going to solve all our problems.

As a primary care specialist, I would be pleased to have pediatricians, and others' fees increased at the price of reducing surgeons' or others' fees, but the issue is much more complicated than that.

Another idea that you need to bear in mind is the current geographic variation in our payments. When you, next year or the year after, begin grappling with redistributing fees across doctors' specialties, you will also have to grapple with the question of how much to pay in Oakland for example and how much to pay in Birmingham for the same service. Those are important considerations.

I do not believe that an RVS fee schedule, on its own, is a wholly satisfactory idea. So let me suggest, in closing, some thoughts about what direction we ought to take in the future.

First, we need a diagnosis of the problem. Medicare physician payment is extremely complicated. We pay a half a million doctors for services grouped around 7,000 codes. We pay 400 million claims a year for physician services. It is a very complicated matter.

Second, as I have indicated on a number of occasions, a fee-for-service payment system contains inherent incentives for physicians to perform more services. That is not, in any way, to imply that my colleagues are out there grubbing for money, but it is to say that a fee-for-service system has biases implicit in it, and we ought to be aware of those as we go about the business of physician payment reform.

A third problem is the lack of a structure in a fee-for-service system for accountability for total costs. Currently, only we in the overall Medicare program, really see the impact of total outlays.

There is no one, especially no one at the local level, in a fee-for-service system who is concerned with rationalizing how doctors are paid, and how other resources are used in the health care system.

And fourth, clinical decisions cannot and should not be regulated from Washington. Medicine is just too complicated, too sensitive for that sort of a regulatory framework to be undertaken successfully. Clinical decisions can best be made and reviewed at the local level.

So what should we do about this? This problem is too complicated for a simple solution, but we have got to be headed in the right direction.

We have got to encourage more accountability for doctors at the local level, give them the autonomy to make the decisions that they wish, and make sure we are headed on a course that will bring us out at the right place several years down the road.

I do not think we fully realize the long-term potential for prepaid, managed care plans in the Medicare program. I have had the opportunity to address this committee several times on that issue in the past. We think it holds substantial promise, the most promise for the future.

What else is there as a possibility? I think preferred provider organizations are an important vehicle along the way to prepaid managed care plans.

Preferred provider organizations are working in some quarters in the private sector. We would like to demonstrate the potential that they have in the Medicare program, and we are well along in the process of selecting some PPO's for such demonstrations in Medicare.

The concept is simple. Certain providers are selected on the basis that they will provide quality health care for the enrollees at favorable prices. Their performance is reviewed, over time, with intensified utilization review, and the poor performers are excluded.

I think that sort of innovation, which is working in the private sector, needs to be tried in the Medicare program. Other ideas that ought to be looked at are further bundling of payments, and other changes of that sort.

This is not something that is going to be solved overnight, but, together, we need to be working on this problem.

I think that the price of failure to manage and control healthcare expenditures better is just too high for physicians, for Government, and for Medicare beneficiaries.

The price constraint policies we have used thus far to control Medicare spending on physician services have had some short-term impact, but they are blunt instruments that will not prevent a future of double-digit outlay increases. That is just an unacceptable outcome.

We have all got to work together to solve this problem. Thank you very much. I will be happy to respond to your questions.

[The statement of Dr. Roper follows:]

STATEMENT OF
WILLIAM L. ROPER, M.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
BEFORE THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
SEPTEMBER 29, 1988

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss the Medicare Part B premium for 1989 and the continuing problem of increasing expenditures under Medicare's Part B. Tomorrow, as required by statute, we will publish in the Federal Register the amount of the premium for calendar year 1989. This notice sets the Part B premium at $27.90 a month, an increase of $3.10 or 12.5 percent over the current premium of $24.80.

Last year when I appeared before the Subcommittee, I had to report to you a premium increase of $6.90 or 38.5 percent. While the news is better this year, the increase is still troublesome.

The Effect of "Catastrophic" on Premiums

A new element in the picture this year results from the Medicare Catastrophic Coverage Act. This legislation dramatically improves Medicare by providing a substantial increase in the protection against the risk every beneficiary faces of devastating medical costs. As you know, this coverage is partly financed by an additional flat premium, which will be paid along with the Part B premium, and an income-related supplemental premium. The flat catastrophic premium for calendar year 1989 is set by statute at four dollars and becomes effective on January 1, 1989.

Some beneficiaries (about 3 percent) will not be required to pay all of the increase in flat premiums (the Part B premium increase and the addition of the $4 catastrophic premium). For individuals who have the Part B premium deducted from their social security checks, the overall increase in flat premiums will be limited so that their social security payment will not go down after both this increase and the social security cost-of-living increase are taken into account.

In addition, the Medicare Catastrophic Coverage Act requires Medicaid to pay Medicare premiums for low-income beneficiaries -- those below the poverty line. The poorest Medicare beneficiaries not only will be protected from the effects of the Part B premium increase, but also will not have to pay either the Part B premium or the catastrophic premium.

Setting the Part B Premium

As I mentioned earlier, the Part B premium for 1989 will be $27.90. For 1989, as for the last five years, the premium has been set to equal one-quarter of estimated Part B expenditures for enrollees aged 65 and over. These expenditures include benefits, administrative costs, and an appropriate contingency margin for the Part B trust fund. Setting the premium at 25 percent of expenditures is required by statute for these years, and the Administration has recommended that this relationship be continued into the future.

If the 25 percent relationship is not continued, the premium increase for 1990 and beyond would be constrained so that it does not exceed the cost of living increase in social security benefits. This constraint was in effect between 1976 and 1983, a period during which Part B expenditures grew more than twice as fast as social security benefits. During this seven-year period, the share of Part B costs borne by beneficiaries through premium payments fell by half -- from the 50 percent figure established at the inception of Medicare to the current level of 25 percent, and the contribution of Part B to the budget deficit more than quadrupled.

Explanation of the 1989 Premium Increase

Several factors explain the $3.10 increase in the premium this year: projected spending increases from 1988 to 1989 (which adds $2.90 to the premium); a correction reflecting lower-than-projected 1988 expenditures (a reduction of 64 cents); the contingency margin (an increase of $1.15); and interest income on trust fund assets (a reduction of 31 cents). (See Table 1.)

Projected spending increases between 1988 and 1989 account for $2.90 or 11.7 percentage points of the 12.5 percent premium increase. Expenditures for physicians' services represent the largest portion of this rise, as would be expected since physicians' services are the largest component of Part B expenditures.

The second component of the 1989 Part B premium is a correction for last year's projection of 1988 spending. Since 1988 Part B expenditures are now estimated to be two-and-one-half percent lower than we projected last year at this time, the 1989 premium will be 64 cents lower than it otherwise would have been. The main reason for this adjustment is the changes enacted by the Administration and the Congress late last year in the Omnibus Budget Reconciliation Act of 1987 (OBRA-87), such as reductions in payments for overpriced procedures. These initiatives did help to check temporarily Part B program growth and consequently, restrain premium growth. The success of these efforts in slowing growth, however, is transitory: they do not represent significant progress toward our goal of bringing health care expenditures under control, and more needs to be done.

The third component of the premium increase is the contingency margin, which accounts for $1.15 of the increase in the Part B premium. The contingency is an amount equal to the cash balance of the trust fund, net of charges for services that have already been provided but for which no payment has been made. The purpose of the contingency is to maintain reserves adequate to cover unpredictable events and to cover any variation between projected and actual costs.

In 1987, the contingency fell to a level somewhat lower than is desirable. In 1988, since a large premium increase was required solely to cover rapidly growing expenditures, very little was added to the 1988 premium to build up the depleted contingency. Current estimates portray the actuarial status of the Part B trust fund as better than anticipated at this time last year, mainly because of the changes enacted in OBRA-87. It still appears, however, that assets will not be sufficient to provide an appropriate contingency. Thus, the $1.15 for the contingency will help build assets to the appropriate contingency level recommended by the Health Care Financing Administration (HCFA) actuaries.

As I noted before the Subcommittee last year, the Part B contingency policy affects only the timing of the impact of increases in Part B costs on the premium. The fundamental driving force of increases in Part B premiums is increases in program costs. To check the growth in premiums, we must control the growth in Part B program expenditures.

Finally, the fourth component of the premium increase is interest earnings on Part B trust fund assets. The premium will be reduced by 31 cents due to this additional trust fund income.

Increases in physician and other Part B spending

Physicians' services represent the largest share of Part B spending -- 60 percent of the total. Other medical services, such as durable medical equipment and clinical laboratory services, account for 11 percent; facility payments for hospital outpatient departments and other institutional services represent 21 percent. Group practice prepayment plans and other services account for the remainder of Part B spending. Thus, the rate of growth in physicians' services drives increases in Part B spending.

Total Medicare spending on physicians' services is large and growing rapidly. In FY 1990 it will be about $27 billion and will represent about 2 percent of the entire Federal budget. Between FY 1981 and FY 1987, Medicare spending for physicians' services per beneficiary increased at a compound annual rate of about 13 percent, almost twice the comparable figure for per capita gross national product. Since the introduction of the prospective payment system for hospitals, Medicare spending for inpatient hospital services has increased at a compounded annual growth rate of about 6 percent per year, compared to about 15 percent for total spending on physicians' services. The growth between 1986 and 1987 was about 18 percent for physicians' services and about 4 percent for inpatient hospital services.

Although we expect the rate of growth in Medicare spending on physicians' services to be moderated somewhat in 1988, 1989, and 1990, largely because of OBRA-87 changes, we expect to experience double-digit rates of increase after that period. Over the next ten years, even without any expansion in the Medicare program, spending for physicians' services will likely triple, even after taking account of the savings provisions enacted in OBRA-87. In part due to the anticipated increases in expenditures on physicians' services, total Medicare spending is expected to exceed spending on social security by about the year 2005, making Medicare the country's largest entitlement program. Both the size and the rate of increase mean that Medicare outlays for physicians' services cannot be ignored.

What is causing the overall increase in spending on physicians' services? Contrary to conventional wisdom, this increase is not driven by the aging of the Medicare population. As I have pointed out to you on other occasions, increases in volume and intensity, which include new services and technology, accounted for about half the increase over the last 10 years. Price increases accounted for the balance. Changes in volume include both changes in the utilization of services and fragmentation of services (which occurs when services that were formerly bundled and billed together are now billed separately). Changes in the intensity or mix of services include both changes in services and changes in coding practices.

HCFA is funding several research studies to give better and more detailed information on the components of the increases in Medicare spending on physicians' services in recent years, and we plan to expand our research funding further in this area. Dr. Janet Mitchell from the Center for Health Economics Research will present some of the first results of these efforts to you during this hearing.

While much of the increase in volume and intensity provides real benefits, there is some unnecessary utilization of services. We are trying new ways to make utilization review more effective, to help ensure that the provision of inappropriate services is minimized. In addition, a growing body of research on medical practice raises serious questions about whether and when some services are effective and whether certain procedures are being performed appropriately.

HCFA and the Department are playing an important role in the area of effectiveness or outcomes research to help physicians choose the most effective medical treatments. Our effectiveness initiative includes analyzing data from Medicare claims processing and peer review activities in order to monitor trends and assess the effectiveness of specific interventions; making available files of Medicare data for use by researchers; funding clinical research demonstrations; and improving methodologies and data bases for performing effectiveness research.

Directions in Medicare Physician Payment

Last May, I pointed out to this Subcommittee that the Federal government does not have an effective mechanism to constrain the rapid growth in spending for physicians' services in the near term. I also noted that growth in Medicare spending on physicians' services is likely to continue to be out of control, and paradoxically, this spending growth will continue to generate strong pressure to bring about control.

One approach that has been advocated by some to change Medicare physician payment rates is to substitute a fee schedule based on a resource-based relative value scale (RBRVS) for the current method of determining fees. We will release shortly the long-awaited report on development of an RBRVS by Professor William Hsiao and his colleagues at Harvard University.

The report essentially concludes that many cognitive services are underpaid while many diagnostic and surgical procedures are overpaid. We plan to conduct a comprehensive analysis of the technical aspects and redistributive impacts of the Harvard RBRVS and include this analysis in our report to Congress, which is due by July 1, 1989.

A fee schedule derived from a resource-based relative value scale would be directed primarily at addressing the problems of inequities in payment rates across different specialties and services. However, it is not a magic bullet capable of solving all the problems of Medicare's payments to physicians. No matter how carefully constructed, a fee schedule for insurance payments cannot be expected to address growth in the volume and intensity of services.

Like the current system of customary, prevailing, and reasonable charges, a fee schedule is merely a mechanism to establish payment rates in a fee-for-service payment system. The problem is that whatever their merits, fee-for-service systems simply do not provide physicians with incentives to control growth in the volume and intensity of services. At best, a revamped fee schedule may send "better" signals, increasing fees for cognitive services as opposed to surgery and other procedures. In the long run, this may influence the choice of specialty among young physicians and may improve the mix of services provided to Medicare beneficiaries.

While improving fees for primary care services is a goal I support, even if an RBRVS based fee schedule were implemented, Congress and the Administration would continue to confront extraordinary pressure to address the issue of rising total expenditures for physicians' services. An RBRVS fee schedule also could worsen the volume and intensity problem if the resulting income redistributions encourage those physicians who face fee reductions to increase the volume or intensity of their services.

Another key issue relating to an RBRVS fee schedule is the redistribution of spending for physicians' services that is likely to occur among geographic areas. The statute requires HCFA to develop indices to measure geographic differences in practice costs. Like the wage index used to adjust hospital PPS payments, a practice cost adjustment could be used to adjust fee schedules among geographic areas. We are now acquiring the necessary data and developing such indices. While it is far too early to indicate definitively the redistributive impacts among geographic areas, many urban areas (such as Manhattan, Miami and

Los Angeles) and even certain rural areas could experience significant across-the-board reductions in fees for physicians' services. You must recognize that such geographic redistributions will create winners and losers among various parts of the country, that many of these changes will be substantial, and that they are likely to lead to political pressures similar to those we have all endured under the hospital prospective payment system.

If a fee schedule -- even one embodying the best research from Harvard and elsewhere -- will not address the problem of rapidly rising outlays, what can we do to deal with the problem? How do we begin to move to a more satisfactory position? What direction should we take?

As a physician, let me begin with a diagnosis of what is wrong and why we have the problem with volume and intensity. First, Medicare physician payment is extremely complicated. Medicare annually pays about 350 million claims to about 500,000 different physicians for services using 7,000 different codes. Administration of such a system is obviously difficult, and the challenge of reforming payment policies in this area appears more formidable than those we faced in introducing the prospective payment system for hospitals.

Second, as I have indicated on a number of occasions, fee-for-service systems contain inherent incentives for physicians to perform more services: the more services that are provided, the more revenue a physician receives. I do not mean to imply that physicians are primarily concerned with finances. Nevertheless, the "open-ended" nature of fees paid by Medicare gives physicians few incentives to be concerned with the total costs of the services they provide or order.

A third problem is the lack of a structure for accountability for total costs. Physicians and other providers generally practice independently and do not coordinate the costs of care with one another. In general, no one but the payor keeps a tab on total costs.

Fourth, clinical decisions cannot and should not be regulated from Washington. Every day physicians make hundreds of clinical decisions that affect health care spending. There are limits to the level of detail that can be or ought to be specified from Washington. Clinical decisions can best be made -- and reviewed -- at the local level.

Considering this diagnosis, let me suggest a course of action. While we will continue efforts, such as intensified utilization review, aimed at sounder management of the system, we must recognize that no simple and universal short-term solution is available. Any solution will require a number of years and a good dose of creativity to develop. We must establish the right general direction, however, and begin to move that way. We must foster arrangements that encourage more accountability by providers for both the price and the quantity of services, yet give physicians the autonomy to make appropriate clinical decisions. If we embark upon this approach, we may not have the answer in two or three years, but we will be on the right course.

I believe that we need to work to realize the long-term potential of prepaid, capitated health plans. This approach provides appropriate incentives to control both the price and quantity of services. Placing decisions regarding fee levels, utilization review, and selection of preferred providers in the hands of plan administrators and physicians at the local level allows each plan to deal with these issues as it deems best, and encourages local managers to deal with both price and utilization. Encouraging a variety of private health plan options also expands choices and opportunities for beneficiaries.

Capitated organizations must, of course, be externally reviewed to assure their compliance with strict quality of care and financial standards. Over the past two years, HCFA has implemented a rigorous peer review organization (PRO) review of the quality of care in HMOs.

Currently about one million Medicare beneficiaries are enrolled in prepaid health plans. As you know, HCFA has been working hard to expand this number. However, despite the advantages, to expect prepaid health plans to change the profile of the Medicare program dramatically in the short term is unrealistic. These changes will come, but not overnight.

What else can we do to deal with the bulk of expenditures that will remain in the fee-for-service sector? Given the diverse nature of our health care system and the complexity of the problems, I believe that a variety of types of managed care and organized delivery structures and systems need to be tried. Some of these alternatives might be stepping stones to capitated systems. A key feature of any alternative should be the ability to move in the direction of addressing the open-ended payment system while providing incentives for the provision of medically necessary services.

One such structure is the preferred provider organization (PPO). PPOs are being used increasingly by the private sector. They are organized delivery systems that provide a framework for management of the health care of enrolled patients. Plan administrators enlist providers who offer high quality care at favorable prices. Provider performance is assessed through intensified utilization review, and poor performers are excluded from participation. While a PPO does not bear risk, it creates incentives for physicians to practice high-quality care efficiently. Through the operation of utilization review and financial incentives, the program has the potential to bring needed pressure on the volume and intensity of services, resulting in more appropriate utilization and patterns of service. We are now soliciting proposals from existing PPOs for demonstrations involving Medicare beneficiaries; we hope to make some awards by early next year.

We need to be creative and try other payment arrangements and organizational structures that can give physicians effective incentives to be concerned with the total costs of care. One alternative might be bundling of payments. For example, we are considering demonstrations that would bundle physician and facility payments for by-pass surgery. Another alternative might be arrangements under which physician groups bear partial risk for some types of services.

Encouragement of other forms of managed care arrangements is not a task that can be accomplished overnight. This task will require time, commitment, and a willingness to engage in trial and error. After all, our finest HMOs took years to develop and mature. The same will be true for other types of managed care arrangements. But we need to make a commitment to move in the direction of fostering an environment in which creative, alternative organizational and reimbursement arrangements can flourish.

Twenty-three years ago, Medicare was designed to buy access to care for beneficiaries by building on the fee-for-service system for the non-aged population. It has been noted that if Medicare were initiated today with the same goal, it might look much different. My point is that Medicare has not followed many of the changes going on in the private market for physicians' and other health care services, particularly in the area of managed care. We should strive to achieve more flexibility and creativity in the Medicare program.

The price of failure better to manage and to control health care expenditures is too high -- for physicians, for the government, and for Medicare beneficiaries. The price-constraint policies we have used thus far to control Medicare spending on physicians' services (freezes, limits on annual updates and overpriced procedure reductions) have had some short-run impact. However, these blunt instruments will not prevent a future of double-digit outlay increases. This outcome is unacceptable. We all share the goal of assuring that high-quality care is provided to Medicare beneficiaries at an affordable cost. We must be prepared to embark on new directions to achieve this goal.

Table 1

COMPONENTS OF INCREASE IN 1989 PART B PREMIUM FROM $24.80 TO $27.90

Total increase in premium	(+$3.10)		+12.5%
Program growth, 1988-89	(+$2.90)		+11.7%
Physicians' and other medical services		6.4%	
Outpatient hospital & other institutions		3.4%	
Group practice prepayment plans		1.5%	
Independent laboratories		0.4%	
Correction for prior projections, 1988	(-$ .64)		-2.6%
Physicians' reasonable charges		-4.5%	
Group practice prepayment plans		1.3%	
Other categories		0.6%	
Contingency reserve	(+$1.15)		+4.6%
Interest	(-$ .31)		-1.2%

Chairman STARK. Mr. Gradison.

Mr. GRADISON. No questions.

Chairman STARK. Mr. Moody.

Mr. MOODY. Dr. Roper, in your judgment, does the current fee system deny access to elderly people as a result of not being able to pay the excessive amount of money, beyond the 20-percent copayment?

Dr. ROPER. No, sir. I think a significant number of physicians are willing to accept assignment. Indeed, more than half of all the claims are accepted on assignment.

We believe that the current arrangement, where doctors have the choice of accepting assignment and patients have the choice to go, or not to go, to doctors who accept assignment, is the appropriate way to leave the program.

Mr. MOODY. So they are not being denied access, as a result of not being able to pay beyond the 20 percent that they are required to pay?

Dr. ROPER. I do not believe so, because of the opportunity they have to choose to go to a doctor who does not bill beyond the standard amount.

Mr. MOODY. Thank you.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman. I wanted to follow up on the question you raised about the contingency fund.

Do you recall what the balances are in HI and SMI trust funds at the moment?

Dr. ROPER. I can get it for you.

Mr. CHANDLER. I tried to find it in our book, and could not.

Dr. ROPER. The balance at the end of the year we estimate will be about $1.3 billion.

[Additional information follows:]

The balance at the end of 1987 was about $8.4 billion for the SMI trust fund and $53.7 billion for the HI trust fund. These balances have not been reduced to reflect incurred, but unpaid, liabilities.

Mr. CHANDLER. And those funds are invested by the Treasury in Treasury bills, is that correct?

Dr. ROPER. Yes, sir.

Mr. CHANDLER. And so the interest income derived by those trust funds are actually interest paid to the Treasury to reimburse people who purchased Treasury bills.

In other words, we are paying interest ourselves to that trust fund, and for members of Congress who devote themselves to the whole range of spending, there really has been no income derived, because we lent it to ourselves, in effect?

Dr. ROPER. The income that is generated from funds being invested accrues to this trust fund.

Mr. CHANDLER. I understand that, but the source of that is some other general fund expenditure to pay interest on the national debt.

So, it is a little thing I like to bring out every once in a while to let people know that we are not investing these funds in anything. We are spending them on current expenses.

And so in fact you could reduce the premium and not bother with the contingency fund because we really have not saved anything anyway.

Another point. You said that by what year Medicare will be larger than Social Security?

Dr. ROPER. 2005 is our current estimate.

Mr. CHANDLER. That is, after the passage of the catastrophic health insurance?

Dr. ROPER. No, sir. That was before the catastrophic legislation. It will be sooner than that, but we have not factored the catastrophic coverage estimates in yet.

Mr. CHANDLER. So we have moved the catastrophic date up a little bit with the passage of that bill. OK. Now, as I understand it, by January 1 of this year, then, the premium part B total, with this addition plus the $4 for the nonincome tax-paying participant will be $27.90?

Dr. ROPER. It will be $27.90 plus $4.

Mr. CHANDLER. Oh. 31.90?

Dr. ROPER. It will be $31.90.

Mr. CHANDLER. Then, after that. And that is a percentage increase over the previous premium of how much?

Dr. ROPER. The premium, as of today, is $24.80.

Mr. CHANDLER. Right. And if we do not extend the 25 percent rule for premiums, which expires, what will the beneficiary share of part B cost be by 1995, if that rule is not extended?

Dr. ROPER. Let me see. Could you say it again? What precise information did you want?

Mr. CHANDLER. What share, then, will be the beneficiary's share, if we do not extend that rule?

Dr. ROPER. It would be, in 1990, 23 percent. In 1991, 21 percent. In 1992, 20. In 1993, 18. And so on.

Mr. CHANDLER. And so 18 percent by 1993?

Dr. ROPER. 1993.

Mr. CHANDLER. All right. Thank you very much, Mr. Chairman.

Chairman STARK. Doctor, may I indulge you for 5 minutes while we go and vote.

Dr. ROPER. Surely.

Chairman STARK. We will recess for 5 minutes.

[Recess.]

Chairman STARK. The committee will resume.

Bill, I don't want to belabor this, but it is something that puzzles me, and if you have looked into it, fine, and I'll let some of you explain it to me later.

Next year there will be an additional $4 flat premium for part B to cover the new catastrophic benefits. About a quarter of that payment will go into a reserve account, most of which is earmarked for prescription drugs, but 20 percent of the payment, or 80 cents of the $4 if it stays at $4, would go into a reserve account.

Now, it would seem to me that the purpose of that reserve account is to protect against the same things that the other reserve account in part B is, although not entirely, because some of it might be used for part A. But have you all been careful that we don't over-reserve?

Between my mother's two Medigap policies, she is only going to get $30 a day but she isn't going to get it from both of them. And I just wonder if you have studied this?

Dr. ROPER. Yes, we have. But the other point I would make in passing is if we do oversave in a given year, "over-reserve," as you put it, that money is not lost to anybody. It is in a bank account earning interest, and it reduces future increases.

Chairman STARK. As we deal with billions of dollars, our constituents and taxpayers are trying to live on $500 a month. And $1 or $ 2 postponed——

Dr. ROPER. Is an important matter.

Chairman STARK. I think I would rather have the payments increase reasonably each year as is needed, than to hold off and have to hit them with a big raise in 3 years. If we can ever find ways to level it out, even if it's only 50 cents a month, it really would make much more of a difference than I think any of us realize.

Dr. ROPER. I think I share your sentiments exactly. We did not prudently set aside enough for the contingency fund, and so had to raise last year's premium by 38 percent. So you have to have a balance.

Chairman STARK. I'll get to what I wanted to talk about here in just a moment.

The expenditure physicians have, let's just say, been running somewhere between a 12- to 15-percent increase. Has anyone suggested a way that we could just say I am sorry, next year it is going to be 10 percent, that is all we have?

How would we then take that reduction and distribute it in such a way that we could continue to get quality care for the beneficiaries? How do we do that?

Dr. ROPER. As long as we have a system that pays on a fee-for-service basis; that is, so much for each office visit or so much for each surgical procedure, there is no way to do what you are suggesting. There is no way to get some overall control of or limitation on the total amount spent, because we are not fully in control of anything except unit prices.

Mr. GRADISON. Would you yield, Mr. Chairman, please?

Chairman STARK. I would be happy to.

Mr. GRADISON. I know at home the IPA HMO, which is basically a fee for service arrangement, withholds a certain portion, and then how much of that gets paid or doesn't get paid at the end of the year depends upon the overall financial system of the fund.

Could that not happen here if we were to hold back a certain percentage and then reckon at the end of the year how much of that should be paid?

Dr. ROPER. Yes, sir. And maybe I was too subtle in my comment. I said as long as we have a regular fee-for-service system, we can't do it that way. But if you lay the kind of arrangement that you described on top, it could be done.

Chairman STARK. I am stating this just as what I observe to be a fact, but during the time you have served as Administrator of HCFA, there has been a $19 to $28 billion a year increase in part B. That is almost a 50 percent increase in 2 years.

I think you and I agree that this just cannot go on or we will have some kind of major problem.

You have observed what the Physician Payment Review Commission is toying with and studying. Do you see anything in their current studies that, in the short run, 5 to 6 years, could get that 15 percent down to 10 percent or down to 8 percent or down to not much more than twice the CPI? If so, which of their various tacks t-a-c-k—seems like the best course to follow?

Dr. **Roper**. I have read Dr. Lee's testimony and find much in common with what he says on several points.

First, I am pleased to see the Commission embracing the idea of better information on medical practice, "effectiveness" we call it. There is a lot to be done on that score. I would not hold that out on its own as a mean of lowering expenditures. Indeed, we may find out, after developing that information, that we are underproviding services to some people, and it may have to balance out.

Chairman **Stark**. Don't medical schools have guidelines now?

Dr. **Roper**. No.

Chairman **Stark**. No. Don't they teach you when to cut my leg off or when to do other sorts of things? They must. When it turns green, you cut. When it turns yellow, you dialysize. There must be some guidelines out there now.

Dr. **Roper**. Yes. There are detailed instructions on how to make clinical judgments, to be clear. But we don't have any kind of rigorous detailed instructions on how to respond to common clinical problems in the way that we give instructions to other people.

Many people have used the analogy of airline pilots—this analogy does not originate with me. But we tend to be comfortable with the idea of giving airline pilots checklists on what to do to get an airplane up in the air; and how to get from Washington to Baltimore; and then how to get the airplane down at the other end.

There is art in flying an airplane as there is art in the practice of medicine. But, we need more rigorous guidelines or standards for medical practice.

So we agree with the Physician Payment Review Commission on that score.

Chairman **Stark**. What I'm thinking of is similar to the guy who takes off from Dulles Airport who reads the same checklist I used to read when I flew an airplane, but still ignores getting the wings deiced.

So do you suspect that if you give a guideline to physicians as a profession that they will accept it readily and eagerly or will they put it on the pile under the medical economics textbook? Will they follow it?

If the guideline is developed, do you think it will be used?

Dr. **Roper**. It will be used provided one very important thing, and that is that it be developed by practicing physicians. It is not enough for people like me or other payers to write down how we think patients ought to be treated. But, if we can get the best minds of practicing physicians to come together and develop these guidelines, I am convinced doctors will use them, because they will welcome that advice. In addition, there is a protection involved. As long as a doctor in rural America practices in accordance with guidelines or standards, he or she will be relatively well protected against malpractice lawsuits. Physicians will have to worry only when they depart from those professionally developed standards.

I think professional guidelines provide an important advantage for practitioners. That was my first point about the Commission's testimony.

The second is, I think, that the idea of overall limitations on payments, the expenditure caps I believe they call them, is an idea that ought to be looked at carefully, as I said to you yesterday. It is a heavy-handed approach, but it is something that ought to be carefully considered.

The one thing that I would say somewhat critically of my colleagues at the Commission is that I don't think they have given due consideration to managed health care—capitation, HMO's, PPO's—as a realistic option that we ought to be investing in heavily. Surely, it is mentioned, and I know that they have devoted some attention to it. But I think we ought to be devoting the lion's share or major part of our resources to that end instead of only including it as part of the longer list of possibilities.

Chairman STARK. Again, I want to say this with as little cynicism as I can, but I am not sure that it is fair to ask these questions of a panel where the majority of the medical professionals come from a fee-for-service background. It is probably where, over the years, capitation has been resisted as a program, and we are asking them to evaluate something which they are probably disposed to not like at the beginning.

I wonder whether it might be necessary for us to study these, to have separate panels look at capitation and/or preferred provider to get an objective sharing of the amount of effort on the study? I see it would be very difficult to get a group of Republicans to get a long hard objective study of socialized medicine. It might be tough to get a bunch of Democrats to do that.

Dr. ROPER. I take your point seriously and I know Dr. Lee does. But I think there is a movement in medicine towards managed care. I am anxious to accelerate that while keeping the options open for other alternative payment systems in our pluralistic system.

The reason I believe so strongly in this managed care, capitation approach is nothing else makes nearly as much sense over the long haul than having local doctors organize and deliver health care services as they see fit, allocate resources as best meets the needs of their patients. That surely is better than us trying to micromanage the system from back here in Washington.

And there is progress to that end among leaders of organized medicine. Dr. Todd may well want to comment on this. A good friend of mine back in Birmingham, a former President of the State Medical Association, is the CEO of an HMO in Birmingham. So there is real movement, even among the leaders of organized medicine, toward managed care.

Chairman STARK. I know HCFA has focused a lot on peer review in overutilization, and I suppose with the HMO's you have to focus on underutilization. That is the flip side of that.

Dr. ROPER. Sure.

Chairman STARK. Is there any evidence that we have beneficiaries gaming the system in overutilizing our services? I would assume there is a small group of individuals who become obsessed with and seek pleasure out of going to the hospital or doctor's office. Has there been any problem with erratic behavior of this nature?

Dr. ROPER. I think one of the real forces driving the health care system is patient demand for services. No question about it.

We have a system in which there are not many barriers to care. We have arbitrarily held down copayments, the sorts of things that might provide a financial disincentive to utilizing services. And we have an increasingly sophisticated public that knows about medical advances and that demands access to those services.

Just a case in point. I was talking to an internist friend the other day who was describing the difficulty that internists have in resisting people's—I started to say "requests"—it is really "demands" for tests of their cholesterol levels. You have seen all the information suggesting "go have your cholesterol checked."

Chairman STARK. Every time I run, I want to go back, did it come down?

Dr. ROPER. Surely we all ought to have our cholesterol checked, and we ought to do it with some periodic repetition, but not every time you think it might be a good idea. Again, standards need to be developed.

Chairman STARK. Let me question you a little on this.

How about hemorrhoid operations, gallbladder removals, proctoscopic examinations? Do you notice any evidence that, as you drop the price of those, people are lining up to have two or three of them? [Laughter.]

I can understand that hypochondria probably grows with education, and you can begin to imagine things. It is convenient perhaps, when you have a common cold, to think maybe you should run to the doctor, just to double-check, even though you know you should just go to bed and take a couple of aspirin.

When I hear about the demand, I constantly want anecdotes of how people are, outside of someone who has a different mental outlook than the average individual. I mean, if there are any real studies, has there been any increase in office visits under Medicare in recent years where prices have changed at all? I doubt it.

Dr. ROPER. In recent years we have seen there has not been an increase in medical office visits. The things that have increased are surgical procedures and other procedures.

Chairman STARK. Don't you think the reason for that is because the price has come down and the beneficiary has so many elective procedures to choose from? You can have cataracts and unless you have them removed, they will still be there 6 months from now or a year from now. Once they're gone, they're gone. Is that it?

Dr. ROPER. Yes.

Chairman STARK. Once your gallbladder is removed, it's gone. You don't take it out twice.

I really wonder though if it isn't the physicians who are promoting more of these procedures, more so than the patient saying can I have this done.

Can you comment on that?

Dr. ROPER. My comment is to say, in general, I don't think there is any single villain here.

Somebody told me after my testimony a year ago that I have been bashing doctors, and I had not intended to do that. And I don't want to bash patients today. I am just saying that we have a system in which all of the incentives are to do more at very little cost to anybody except, in our case, the Medicare program. And I think we can turn that around.

Chairman STARK. If what you are saying is that there is less resistance by patients to take a doctor's advice to have an invasive procedure, I will agree. But I would challenge you a little bit to give anecdotes of where the patient was encouraging the physicians to do uncomfortable, unpleasant procedures, which I think are also the most expensive ones.

That is why I tend to want to discount the question of patients. We could raise copays, but I don't think that is going to save us much money. I really don't. Maybe if we did it on x rays, but most of us don't go to see the radiologist on our own. That's done as a result of some doctor we talked to who refers us to the radiologist who in that instance is secondary.

I made my point.

Mr. Gradison, do you have anything further?

Mr. GRADISON. Thank you, Mr. Chairman.

Dr. Roper, last year the increase from a beneficiary's point of view was $6.90. This year it is $7.10.

Now, granted, at least in the eyes of those of us who supported the catastrophic health insurance bill, we are getting a better deal, a better package of benefits, but it sounds like we're going to find out pretty quickly if they feel it's sufficiently better to justify an increase which is in dollars, roughly the same as last year's, about $7 last year, about $7 this year, and obviously there was a lot of resistance to last year's.

This question is really very picky, but I just want to make sure I understand this.

Your prepared statement said that tomorrow you will publish in The Federal Register the part B premium of $27.90. I understand that. But why isn't the other $4 included in that Federal Register announcement? Also, if the actual total amount that the beneficiary is going to pay is going to be $31.90 rather than $27.90.

Dr. ROPER. It may well be mentioned in tomorrow's notice. We will find out for sure and let you know.

The reason for tomorrow's notice in the Federal Register is a legal requirement that, at the end of September every year, we provide a public notice of what the premium is going to be.

I would believe that we take note of the fact that accompanying this will be the $4 increase. And I was just told that it is in tomorrow's notice.

Mr. GRADISON. I appreciate the $4 was set by statute and not discretionary. But I was just kind of curious about that.

Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody?

Mr. MOODY. Thank you.

You and the chairman were discussing a minute ago anecdotal evidence about patient demand changes with respect to price.

How about doctors' behavior with respect to price? Are there any studies, not anecdotal, but econometric type studies, which try to measure the elasticity of volume with respect to changes in price? I assume it's a very, very important issue to try to quantify. Whether the demand comes from the doctors or from the patient, to what extent does volume react to price, net price, revenue price to the doctor or out-of-pocket cost to the consumer?

Dr. **Roper**. You have asked a very good question, sir. I would be glad to give you an answer for the record. I just don't know the research literature that well.

Dr. Mitchell, who follows me, may be able to comment on that.

Mr. **Moody**. I would appreciate it. I would assume that volume in general is a function of, on the one hand, price; on the other hand, aging, and other variables we might suggest.

I see that the AMA testimony says that the volume change is a result of aging, a shift to outpatient setting, and an increased beneficiary demand—they don't say doctor demand. Those three things explain most of the growth in the payments, Part B.

Let's look at the second item. We've already asked you about price, and I would appreciate if you could follow up with some information.

Dr. **Roper**. Sure.

[Additional information follows:]

We have conducted a number of research studies to better understand the factors that contribute to the increase in physician payment costs. These studies show that the problem is very complex and that it is difficult to conclusively sort out the cause(s) of increases in cost and volume of physician services since there are many contributing factors. The research indicates several reasons for the increased physician costs, including the incentives in a fee-for-service system to increase volume of services; the growth in the supply of physicians; the impact of technology; implementation of new coding and billing systems; and the ineffectiveness of payment limits or freezes. We are carefully reviewing the results of these studies and expanding our analyses to better understand the problem and solutions.

Mr. **Moody**. On the second item, they mention the shift of care to outpatient, as a result of the DRG's, which have reduced hospital stay lengths. We hear anecdotal comments that this has only resulted in part B expenditure increases.

Do you have any measurement of that shift factor, that displacement factor?

Dr. **Roper**. Yes, sir. More procedures, surgical procedures especially, are now done as an outpatient rather than as an inpatient service. But that doesn't explain this change that we have seen in total outlays. Because, remember, what we are talking about is part B, payment for physician services, and we paid surgeons' fees for ophthalmologists to do in-hospital——

Mr. **Moody**. Or outpatients.

Dr. **Roper** [continuing]. Cataract removal, and we are going to pay a surgeon's fee as an outpatient.

Mr. **Moody**. So there is no reason to think that the DRG's or other things that shorten hospital stays have driven up total expenditure on part B, or have they?

Dr. **Roper**. It is a bit more complicated than what I just told you. But my general answer is that doesn't fully explain——

Mr. **Moody**. Not fully, but is it a significant component in this?

Dr. **Roper**. It is not a dominant one, no, sir.

Mr. **Moody**. It is not?

Dr. **Roper**. No, sir.

Mr. **Moody**. But is it a measurable one?

Dr. ROPER. The subtlety that I have glossed over is for some of the outpatient surgery, there is now a payment within part B for the facility fee.

Mr. MOODY. Which would otherwise be in part A?

Dr. ROPER. Yes. But again, that is not the dominant explanation for this increase.

There are literally more activities being engaged in, more procedures, not just those being displaced from the inpatient to outpatient setting.

Mr. MOODY. Is the fact that more procedures are occurring influenced by the setting? Is a procedure more apt to take place because it is in an outpatient setting than an inpatient setting?

I would think it might be the other way around—the procedure might be more apt to take place if the patient is in an inpatient setting.

Dr. ROPER. But more and more things are being done as an outpatient because it is more comfortable. Most patients would rather have services rendered in that fashion. But let me be fully responsive to your question.

This is a very complicated matter, and a number of changes have happened in recent years, all at the same time. It's truly difficult, if not impossible, to disentangle what happened because of a specific change. I am not trying to dodge your questions, but I don't think anybody knows the answers to some of those things.

Mr. MOODY. Have we tried the model behavior with econometric or other studies?

Dr. ROPER. Yes, sir.

Mr. MOODY. I would appreciate a kind of survey of the literature.

Dr. ROPER. I would be glad to submit a report fully on that to you.

[The information follows:]

We have funded a number of studies to better understand the issues underlying increases in payment for physician services. While we have improved our understanding of many of the factors causing increased physician service costs, the research shows that it is difficult to attribute a cause and effect to any one factor. Many of our studies include econometric models, while others are descriptive. A review of the available literature shows a number of studies that address the issue of elasticity of volume with respect to price and the shift of services from inpatient to outpatient setting. The key studies and the findings of this research to date are:

Urban Institute—"Analysis of Changes in Physicians' Medicare Revenues"—This 1981 study examined changes in physicians' services and revenues before and after the introduction of the Economic Index. The study found that the index only had a significantly constraining effect on Medicare rates in its first year. There was also a reduction in the number of physicians that billed Medicare, a shift from assigned to nonassigned billing, and increase in patient financial burden.

Blue Cross/Blue Shield of Michigan—"The Impact of Physician Supply and Regulation of Physician Fees and Utilization of Services"—This 1985 study developed a model of the impact of the usual, customary, and reasonable reimbursement method on physician prices in one state. Analysis showed that geographic disparities in the level and growth of physician services, and not fees, provide a major impetus to physician expenditure growth. The study also found that availability of physician services generated more service use. As a result, the study concluded that it might be academic whether physicians consciously shift demand, unconsciously follow established practice patterns that raise utilization, or are simply more readily available to patients. The challenge is how to use greater physician supply to advantage.

Center for Health Economics Research (CHER), "Physician Losses from Medicare and Medicaid Discounts; How Real Are They?"—This 1985 study analyzed claims from primary care physicians and determined that the physicians' usual charge is higher than Medicare and Medicaid allowables. Since the usual, customary and reasonable payment methodology encourages physicians to use fees to maximize payment, the study concludes that raising allowables to the physicians' usual fee will result in large windfall gains that are unnecessary and unjustified in terms of work effort, human capital investment, or eliciting an adequate supply of practitioners.

Center for Health Economics Research—"Relative Incomes and rates of Return for U.S. Physicians"—This study shows that real incomes of physicians did decline between 1967 and 1980, but that this was apparently due to economy-made events since the same income trends were found with other professionals. The rate of return for medical training (in particular for specialists) remained high—between 14-17 perent in 1980. While Medicare and Medicaid fee discounts have been criticized as inequitable, the programs provide a "hidden subsidy" to physicians during residency training, materially adding to rates of return for education.

Center for Health Economics Research—"Physician Participation in Public Programs"—This 1981 study provides a comprehensive review of physician characteristics and data from the 1975, 1976 and 1977 Physician Practice and Income Survey. It also includes an econometric model which analyzes physicians' decisions to accept Medicare assignment and to treat Medicaid patients.

Boston University/CHER—"Physician Behavior Under the Medicare Assignment Option"—This study analyzed physician assignment patterns in the early 1980s and concluded that a growing number of general practitioners and internists are unwilling to accept assignment; general surgeons and foreign medical graduates disproportionately took assignment. The study concluded that while increases in Medicare allowed charges should raise net assignment rates, such increases may result in higher out-of-pocket costs or forcing some patients out of the market altogether.

Pennsylvania Blue Shield—"Study of Physicians' Services Market in Pennsylvania"—This 1983 study considered physician pricing patterns, factors related to pricing practices, econometric analyses of the market and participation in Blue Shield and Medicare in Pennsylvania. The study found a substantial degree of variation in physician fees for most procedures; differences in fees between Medicare and Blue Shield programs; and a conclusion that most physicians consistently accept or decline assignment.

Urban Institute—"Aspects of Physician Behavior, Service Delivery and Payment Methods in Medicare and Medicaid"—This 1984 study summarized findings from studies of California physicians' Medicare and Medicaid claims billing experience including the impact of the economic index; impact on assignment and participation; and the relationship between reimbursement incentives and geographic mobility of physicians.

City University of New York—"Alternative Approaches to Physician Reimbursement Under Medicare: A Simulation"—This 1979 study simulates likely effects upon program outlays, physician revenue and Medicare beneficiary out-of-pocket liability that could result from altering methods to determine Medicare part B prevailing charges. The study concluded that eliminating the MEI would increase outlays by 8.7 percent; paying a single prevailing charge for all specialty designations combined would reduce outlays by 1.9 percent.

Princeton—"The Compensation of Physicians: Approaches Used in Other Countries"—This 1983 study examined the role of fee schedules in physician reimbursement under third party payment systems in Europe and Canada. The analyses included comparisons with relative price structures in the U.S.

Harvard—"Toward Developing a Relative Value Scale for Medical and Surgical Services"—This project developed a methodology to determine the relative values of surgical procedures and medical office visits on the basis of resource costs. The study found discrepancies between reimbursement levels and resource cost values for office visits compared to surgical procedures and indicate that on average office visits are undervalued by four- to five-fold.

Urban Institute—"Price Controls, Physicians' Fees, Output and Revenue from Public Medical Programs: Evidence from Five Specialties"—This 1979 study examined the response of five specialties to the Economic Stabilization Program. They found that physicians provided more services and were less likely to accept assignment. As a result, the percentage increase in total Medicare payments to physicians increased by considerable more than the allowed percentage increase in fees.

Center for Economic Research—"What Should Medicare Pay for Surgical Procedures"—This study examined whether technological changes that have greatly reduced time inputs and other physician costs mean that Medicare payments for procedures most affected by technological change are too high. The study considers 1984 claims data from 4 states.

Center for Economic Research—"Impact of Medicare Fee Freeze and Participation Agreement on Physicians"—This study found that Medicare physician expenditures per beneficiary increased 35.5 percent during the 1983-86 fee freeze in four states. Total spending on surgical procedures is by far the most important factor. There was also a dramatic shift in services to outpatient settings and physicians may be billing for more expensive visit codes.

Project Hope—"The Economics of DRG-Based Physician Reimbursement"—This 1985 study includes a literature review and considers physician payment reform options. The study concludes that payment based on procedure has undesirable incentives for unbundling, upcoding, multiple physician involvement, and overspecialization. The study finds that fee screens are a relatively inflationary pricing mechanism and that fee controls or freezes have had limited success. In addition, if capitation is the goal, the study finds that payment based on case is not a good intermediate step.

Mr. MOODY. Another thing that doctors tell me in my district is malpractice insurance rate premiums have increased so fast, and that has driven up their costs.

Have you analyzed this? How much validity is there in the so-called malpractice explanation of soaring costs?

Dr. ROPER. There are two parts to that. One is the actual cost of practice going up as a result of doctors' premiums going up, and that's a real factor.

The other thing is the degree to which doctors do things they wouldn't otherwise do.

Mr. MOODY. Defensive medicine.

Dr. ROPER. Defensive medicine.

Mr. MOODY. I am just asking about the first item, on how much the actual of malpractice insurance has driven up doctors' fees?

Dr. ROPER. Again I would be glad to supply that for the record. I don't know what the last year's average increase in malpractice premiums is, and what fraction that adds to the cost.

[Additional information follows:]

The average medical liability insurance costs for all physicians have steadily increased from 1968 through 1985, with a brief lull in the late 1970s. The total amount spent on malpractice insurance premiums increased from $2.4 billion in 1983 to $3.8 billion in 1985. The average physician experienced an 81 percent increase in malpractice premiums from 1982 to 1985; however this average is somewhat misleading because the increase was much larger for physicians in obstetrics/gynecology (113 percent) and family practice (91 percent). In addition, there is considerable variation in malpractice insurance costs from state to state, with the highest premiums in Florida, Illinois, Michigan, New York and the District of Columbia. It should be noted that premium increases are due not only to average premium increases per physician but also to the increase in the total number of physicians.

Malpractice insurance premiums represent a small portion of overall physicians' expenses in operating a medical practice. Malpractice premiums rank fourth in expenses after non-physician payroll, office expenses, and medical supplies. However, average malpractice expenses have increased more than other expense items. The percent change in average physicians' expenses from 1982-1984 was: malpractice—45 percent; office expenses—37 percent; supplies—35 percent; and payroll—1 percent.

Our data do not break out the relationship between physician malpractice costs and the increase in physician fees or total physician payment costs. However, we do know that physician and hospital malpractice insurance costs combined have increased from 0.9 percent of the national health care budget in 1983 to 1.22 percent in 1985. This represents a 33 percent increase.

Mr. MOODY. There are major initiatives for "tort reform" around this Nation, both at the State legislative level and, of course, in Congress. And one of the arguments is, of course, that malpractice fees are driving up medical fees.

Dr. ROPER. I believe that.

Mr. Moody. And if you could quantify that for us, it would certainly enlighten the dialect.

Dr. Roper. It is not for lack of interest that I don't have full answers for you.

Secretary Bowen, in response to the President's request, studied that issue, and we had our actuaries look at those questions, as has the AMA and others. And nobody knows.

Mr. Moody. So you don't really have an answer at this time. They just have not been able to derive an answer, or you don't have one?

Dr. Roper. That's it.

Chairman **Stark.** Would the gentleman yield?

Mr. Moody. Certainly.

Chairman **Stark.** In the discussion yesterday, and I am not sure this helps, but the total premium for malpractice insurance was around $5 billion, and a rough estimate for the Medicare share of that might be $2 billion, or $1½ to $2 billion.

To the extent that this is the cost to Medicare, that's as close as we got, and that was the back of the envelope that had the calculations.

Mr. Moody. Thank you.

Finally, if I can just take another minute to ask you another kind of a question, about a part A issue now, if you don't mind shifting gears for a second.

Dr. Roper. Yes, sir.

Mr. Moody. Let's look at, say, an appendectomy—let's say in Cleveland, Ohio, or Milwaukee, Wisconsin, my town. What would happen if Medicare, as a near monopoly in the market, could ask various hospitals in Cleveland or Milwaukee "How much would an appendectomy, absent special complications, cost?" and then pick the price based on the hospital that was most cost-effective, making that the price medicare will pay in Cleveland. If another hospital wants to charge more, then that is their problem.

Why couldn't that be the price ceiling for that geographical location? I remember yesterday in our private briefing we talked about the inability to have price competition in the medical field. But there are some cases where you really could have price competition.

Dr. Roper. I like your idea. That is generally described as competitive bidding. Mr. Gradison is one of the people who reminds me repeatedly that we ought to be trying competitive bidding in the Medicare program.

Mr. Moody was asking me what I thought about bidding hospital services in a local market. I think it is a great idea, provided we can provide assurances for quality and access and so on. But, yes, I like the idea.

Mr. Gradison. Would the gentleman yield just briefly?

Mr. Moody. Sure. You and I have discussed this before.

Mr. Gradison. We have. In some, you know, I've been concerned—I think we all have really—about the relatively abrasive way in which we go about dealing with each other and dealing with groups, the Congress versus the Administration, the relations with the AMA and all that.

And it seems to me that we ought to think through the possibility with regard to physician services of letting physicians set the fees themselves through public bidding, with an arrangement so that the high bidders either get none of the business for a year or get a lower amount of payment than the low bidders. And I think that could be used as a way to measure the conversion factor and tie in very well with the Hsiao study.

So I am glad the gentleman brought this thing up, and I think it just goes back to market principles and, frankly, it becomes a lot less abrasive, let the market make this determination. Because the hospitals themselves would be setting the fee. We wouldn't be imposing a fee, we would be shopping among hospitals that are actually offering this service, and that would become the norm for that location.

Dr. Roper. Another virtue of competitive bidding is that it would establish different prices in different areas, depending on the capacity of that local area to support competition; for example, in rural areas, as there ought to be, the prices would go up; in areas where there is an excess supply of beds, the prices would go down.

Mr. Moody. It would simulate a market situation reflecting differential costs and differential supply or shortage of those facilities.

Dr. Roper. It is an appealing concept. My points about the need to assure access and quality are key and ought not to be treated lightly. But I like the idea.

Mr. Pickle. Dr. Roper, you have made the statement today and referred to us yesterday that some of our rural areas might feel a negative impact on physician payment if there was adoption of the RVS. What is the basis of your analysis that they might be hurt?

Dr. Roper. What I said, sir, is that a key consideration in implementing a fee schedule is the geographic variation in that fee schedule. You have asked us to come forward with a report at the end of this year, and then another one a year in the future, on a geographic cost of practice scale. Our preliminary results to date indicate that in some rural areas, despite our hopes and intuition, there would be lower payments.

Mr. Pickle. I understand.

Dr. Roper. That is something we are still working through.

Mr. Pickle. I understand you made reference primarily to certain geographic big urban areas, Miami, Los Angeles, and so forth. But you said it might have a negative impact in rural areas. I am asking you now, what do you base that one?

Dr. Roper. This study that my staff are doing about the costs of practice in various geographic areas.

Mr. Pickle. I am sorry. I did not understand you.

Dr. Roper. What I base that on is a study that the HCFA staff are doing of the differences in cost.

Mr. Pickle. Can we have a copy of that study or an analysis of that study? I am just trying to find out why. Because rural hospitals, rural physicians—we are having a great difficulty maintaining them, in just keeping them a viable entity. If doctors are hurt by the physician payment, that in turn is going to have a negative impact on the hospitals in the rural area. They are having an extremely difficult time now. We are talking about part B now, but you can hardly separate some of these things from part B and part A when you get to talking about hospital fees and the cost.

I am trying to find out, I want to understand more why the rural physician might be hurt. And this brings up another question, not on part B—and I will talk to you or your staff about that later. When we try to establish rates for urban and rural, you still use the 1980 census figures for determining what those cost. Why do you do that? Why can't you use more up to date data? We do that all the time in many, many programs.

As I understand it, you refuse to update the classification on, say, 1986 or 1987 census data figures. Why?

Dr. **Roper**. We do not always say we have to follow the 1980 census.

Mr. **Pickle**. Well, in this case, you do.

Dr. **Roper**. What we have said is we need a general standard census for everybody, and some particular areas have come forward to us and said they have done a special census in their county that showed these results. We need a standard that the whole country can answer to. That is why we have asked for fairly understood standards.

Mr. **Pickle**. I think Senator Bentsen has written you and asked you why can't you use more up-to-date figures. This is 1988, and you still use the 1980 figures.

Dr. **Roper**. I understand.

Mr. **Pickle**. There have been a lot of changes made. And I think if you just arbitrarily say, no, we are going to use 1980 figures, it just does not make sense. Now, we are trying to give some kind of explanation to the rural hospitals. What can we tell them, except that it is the law?

Well, I am telling you, get that law updated.

Dr. **Roper**. Yes, sir.

Mr. **Pickle**. And if you do not, we may do something about it ourselves. But we will just make an appeal to you first. I am asking you why. Any matter you can give to me would be helpful, any information.

Dr. **Roper**. I would be glad to do that.

[The information follows:]

Medicare regulations are developed using the most recent data available. We believe that it would be unfair to pay additional monies to certain areas of the country by using a data source that is not available to all areas of the country. In some cases, we have our own program data to determine payment, but in other cases we must rely on other parts of the government, such as the Census Bureau, to provide certain types of data.

Following are three examples of different data that we use to establish our payment rates to hospitals under the prospective payment system (PPS).

In setting rates for urban and rural hospitals under the prospective payment system (PPS), we used the most recent data available (1981) from hospital cost reports.

We use 1980 census data to implement the provision that will pay certain hospitals in rural counties at the higher urban rate if they meet certain conditions specified in law. One of these criteria is commuting rates for which the most recent national data available is the data used by the Office of Management and Budget in designating Metropolitan Statistical Areas. This data will not be collected again by the Census Bureau until 1990. While some counties may have more recent data on commuting patterns from sources other than the national census, not all areas of the country have access to the same type of data. We will change our data as soon as we have national numbers.

We use 1986 census data to determine which urban areas qualify for the large urban update. This more recent data is available because the Census Bureau gathers population data more frequently than it collects commuting data.

Mr. PICKLE. And now on with respect to the part B, I have to say we have to assume again if they were to adopt these RVS, that in itself would not control the expenditure level, would it?

Dr. ROPER. No, sir.

Mr. PICKLE. So that is still a problem for us.

Dr. ROPER. Yes, sir. It would provide prices that would be different, presumably fairer prices. But it would not deal with the full equation.

Mr. PICKLE. All right. I thank you. I have got to go vote.

I will yield back my time, Mr. Coyne.

Mr. COYNE. Thank you, Dr. Roper. We will recess until the vote is over and the other members return.

[Recess.]

Chairman STARK. Our next witness will be Dr. Philip R. Lee, the chairman of the Physician Payment Review Commission, affectionately known as PhysPRC. We have your prepared testimony. Please enlighten us in any way you are comfortable.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL B. GINSBURG, EXECUTIVE DIRECTOR

Dr. LEE. Thank you, Mr. Chairman. I do appreciate the opportunity to come before the committee. I am accompanied by Paul Ginsburg, who is the executive director of the Commission.

In my prepared testimony, we deal initially with the increase in part B expenditures, and also with the factors contributing to those increases. As you and Dr. Roper have already discussed that in some detail, and as Dr. Mitchell and Dr. Todd will also discuss that, I will move directly to my comments on the role of the Commission or the actions the Commission has proposed to take. If you would turn to page 5 of the testimony, that is where we talk about the work of the Commission.

Congress created the Commission to advise it on the reform of Medicare physician payment. The Commission is committed to bringing recommendations to Congress next March that include a fee schedule for Medicare and a strategy to restrain the growth in outlays for physician services that does not adversely affect quality or access to care.

A fee schedule is intended to correct deficiencies in the current "customary, prevailing and reasonable" payment method that are generally recognized by all parties affected by Medicare policy.

A fee schedule based on the resource costs of providing physician services is likely to encourage more appropriate choices about which services are provided to patients, but it generally retains, as Dr. Roper pointed out, the incentives for utilization, or some would say overutilization inherent in fee-for-service payment methods. While it would represent a significant improvement over the current payment method, a fee schedule alone will not control the costs of physician services sufficiently, nor ensure that patients receive the services most appropriate for their needs. We will also need more direct measures that focus on selectively reducing services of least benefit without threatening the many valuable services for which Medicare pays.

The challenge before us is to control the rapid growth in service volume not by reducing access to necessary care, but through measures that assure more appropriate provision of services.

In our last report to Congress, we described several underlying requirements for a strategy to meet the dual goals of controlling volume growth and maintaining access to quality care. First, Medicare beneficiaries and their physicians must be willing to forgo services of little or no benefit. Second, all parties—physicians, beneficiaries, and others who influence medical choices—must have more usable and complete information about the effectiveness of alternative medical services. And, third, there must be incentives to use such information to eliminate unnecessary or minimally beneficial care.

I would just like to say as a comment here, Mr. Chairman, in response to your question about patient demand. There are some, I think, good examples of where patient-induced demand has been significant. After the President's colon surgery, there was a big increase in colonoscopies. As you pointed out, there has been an increase in demand for cholesterol tests on the part of the patient. When NIH developed its highly successful national program for high blood pressure control, there was a big increase in office visits for the treatment of high blood pressure with strikingly beneficial results, I might add. The drop in mortality was significant.

There is an interface obviously, but those were, in some way, consumer generated.

Chairman **Stark**. My guess is, and this is just my instinct, that the kinds of things you are talking about—inspections, tests—ought to yield a lot lower cost in the future because that generally has been accepted as the nature of preventive procedures. If the evidence is that the high costs have come from surgery, I can understand a person wanting more tests, maybe hearing about a new disease and wondering whether they can prevent it. That makes sense. I believe this is not even the very high cost part. Studies show we have the highest payments and I suppose the highest percentage of Medicare goes to pay for unnecessary procedures. I just wonder if this is significant.

I think we should encourage the demand of annual physicals and the demand of blood tests, although certainly not excessive. It does, however, seem to me to be the physicians role to say, you do not need this test. So in a sense, it is there——

Dr. **Lee**. A big factor in the increase in costs was what we called little ticket items: laboratory tests, routine x rays, that sort of thing. In the 1980's, it has been much more a shift to what are called big ticket items: MRI's, CAT scans, coronary artery bypass graft surgery, total hip replacement, cataract surgery—those high cost items. And some of the things that Mr. Gradison and you both mentioned earlier and Mr. Moody, about what some would call selective contracting for some of those services, is one of the things we will be talking about a little bit later when we talk about expenditure targets.

To go on with the testimony, first of all, practice guidelines. Dr. Roper mentioned these and commented on them. There is increasing evidence that beneficiaries receive services that are unnecessary and fail to receive some services that would benefit them.

These inappropriate procedures reduce the quality of care, increase the cost, and, of course, put the patient at some risk.

Substantial variation in the use of services among geographic areas has been documented for hospitalization and many procedures.

Scholars have attributed much of the geographic variation and the use of unnecessary services to uncertainty among physicians as to what services are appropriate for their patients.

Incomplete knowledge of the risks and benefits of medical services and procedures also limits the effectiveness of utilization and quality review.

There are two ways to increase what we know about the risks and benefits of medical services: first, clinical and health services research on effectiveness, and second, the development of practice guidelines that draw on this research and on the clinical experience of practicing physicians.

Practice guidelines are essentially clinical recommendations for patient care. They provide guidance to physicians and others who must make decisions about the use of specific medical services. Formally developed guidelines provide a way to synthesize existing knowledge, extend it through the consensus of expert physicians, and make it available in usable form.

And I would say in response to a question you raised with Dr. Roper that, in fact, there are intern manuals or manuals for interns and residents. One of the best was developed by the medical school at Washington University in St. Louis. I can remember for many years, as both a resident and as a practitioner, often carrying that manual in my pocket, particularly when you were going to encounter or might encounter an emergency. You might not be totally familiar with the problems. You had it readily available. So we have had them for years. It is not something that is suddenly appearing. But the interest in them on the part of the College of Cardiology, the College of Physicians, I think has been exemplary and a very important recent development.

The Federal Government also has an important role to play in laying the groundwork for higher quality and more efficient care through, first of all, support of clinical and health services research, on effectiveness, and encouraging the development of practice guidelines.

One of the things that the Commission will be doing is hosting a conference in Washington on October 11 to discuss questions about how guidelines should be developed and used, and what role might be most appropriate for the Federal Government. We expect the conference to help the Commission and others develop a sound strategy for the development and use of guidelines. They are not a panacea, but they are very important. And I agree with Dr. Roper's comments that they certainly would be used by physicians if they were developed by physicians who were going to be using those procedures.

Let me say a little bit about expenditure targets, because this is, we think, a very important area. Dr. Roper used the word "heavy-handed." I do not agree with that. We think this is perhaps a way to provide incentives for physicians to really become involved in utilization review and in the control of the use of services.

Under a system of expenditure targets, updates of physicians' fees in an area would be adjusted on the basis of how total expenditures compared with a predetermined target. If the physicians in an area effectively controlled the volume of services in that area, they would receive the full schedule of fee increases, or perhaps even more. The intent of expenditure targets is to have the physician community take responsibility for the appropriate use of medical services, and to rely on the medical profession to develop or support specific measures to accomplish this.

Mr. Gradison talked about the use of a reserve fund or a withhold. That is another approach to the expenditure target option.

Expenditure targets may provide a means for controlling Medicare program costs by creating incentives for physicians in a defined geographical area to work together to reduce unnecessary, ineffective and inefficient use of medical services. They also could bring beneficiaries a lower rate of increase in part B premiums and in coinsurance liability, even if physicians did not respond by slowing increases in the volume of services. And, for taxpayers, expenditure targets could slow the rise of Medicare program costs.

The impact of expenditure targets on service use will depend heavily on the willingness and ability of physicians as a group to respond constructively to this collective incentive to reduce inappropriate services, and thus to moderate expenditure growth. The assumption underlying expenditure targets is that placing physicians collectively at risk could lead to stronger collective interest and participation by the profession in the development of practice guidelines, physician education and effective utilization review. The Commission is exploring whether and how physician involvement in administering the expenditure target could be ensured. It is developing a series of organizational models that range from modest changes in the current Medicare review system, to a more fundamental restructuring that places greater responsibility on the medical profession.

Expenditure targets are likely to have a positive effect on patient care as well as program costs only if the physician community considers them a legitimate means to a reasonable end. This in turn depends on two conditions. First, the targets have to be economically reasonable. Second, physicians reimbursed by Medicare have to be involved in the development and administration of the utilization and quality reviews, and committed to making the reviews productive.

The Commission's work is proceeding in several areas in addition to our efforts to define an appropriate organizational structure, and these are outlined in my testimony.

The Commission is exploring alternative implementation strategies that provide credible incentives to stimulate a constructive response from physicians, and yet are sufficiently gradual to permit the development of a structure that will assure the effectiveness of the policies over the long term.

In summary, Mr. Chairman, sound policies must be developed that will reduce the rate of increase in Medicare spending for physician services while maintaining access to high quality care for

Medicare beneficiaries. Those measures must focus on selectively reducing services of least benefit, by providing both better information on the effectiveness of medical services and greater incentives to use that information. The Commission is assessing the potential for practice guidelines and expenditure targets together to provide a strategy that will moderate part B spending. And we do not exclude the capitation approaches that were also mentioned by Dr. Roper, or what might more broadly be called managed care options.

Thank you.

[The statement of Dr. Lee follows:]

STATEMENT OF THE

PHYSICIAN PAYMENT REVIEW COMMISSION

PHILIP R. LEE, M.D.
CHAIRMAN

Mr. Chairman, I appreciate the opportunity to come before you and members of this Subcommittee to share the views of the Physician Payment Review Commission on the continued increase in Part B expenditures and the resulting increase in the premium paid by beneficiaries. Today, I want to review with the Subcommittee the factors contributing to Part B expenditure growth and the work the Commission has initiated to address this problem.

The Commission is concerned about Part B premium increases both because of their financial impact on beneficiaries and because they are a reflection of the sustained growth in expenditures for physician services. Physician services account for about 75 percent of Part B expenditures. Total Medicare outlays for Part B increased roughly 18 percent a year between 1975 and 1986, with expenditures for physician services increasing at nearly the same rate as total outlays. Last year, the impact of this continuing trend was once again brought home to beneficiaries by the decision that Part B premiums would increase by 38.5 percent to help meet rising expenditures.

This year the growth in expenditures is somewhat below that of the last two years, but the pattern remains consistent with long term trends: the rate of increase continues to be far above what would be expected from general price inflation and growth in the number of elderly beneficiaries. In fact, price increases and growth in beneficiary enrollment have accounted for only slightly over half of the increase in outlays since 1975. Increases in services per enrollee alone (often referred to as the volume of services) were responsible for 44 percent of the rise in expenditures between 1975 and 1985.

Analyses conducted by Janet Mitchell on changes in Medicare expenditures and volume of services show that Medicare physician expenditures per beneficiary increased by 35 percent over the four-year period from 1983 through 1986.[1] The rate of expenditure growth or service use, however, was not uniform for different categories of services, for specific services or for services provided by physicians in an individual specialty.

For example, three kinds of services grew at above-average rates: surgery, radiology and specialized tests. Increased spending for surgery was the single most important contributor to expenditure growth during the period. Even within surgery, some services declined in frequency while others, such as cataract surgery and coronary artery bypass surgery, increased substantially. The results of this analysis show the rapidity of change within medical practice and its effect on Medicare expenditures.

The development of policies to reduce the rate of expenditure growth is an important part of any reform strategy the Commission will consider. The Commission is concerned not just with how much Medicare spends but with the services on which Medicare dollars are spent.

FACTORS AFFECTING THE GROWTH IN EXPENDITURES

In testimony before this Committee last year, the Commission noted that the job of designing sound policies to slow the growth in service use is complicated because many factors affect the trends we see. The number of medical services provided is ultimately the result of decisions made by physicians and beneficiaries. Each responds to the information available on what care is indicated and to financial, legal, technological and other considerations about how to proceed.

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[1] Janet Mitchell presented the results of her analysis to the Commission at its meeting on July 14, 1988.

Some of the increase in services comes from improvements in medical organization and technology and from a reduction in unmet need through deliberate changes in policy to improve access to care. Advances in medical technology also may add new services or lead to different applications that increase total services provided for a given medical problem. These services may significantly improve the outcomes of care, particularly in terms of quality of life for beneficiaries.

Incentives inherent in a fee-for-service payment system also may affect medical care decisions by physicians and beneficiaries. Physicians are clearly the primary decision makers about the use of medical services, including their own services. As agents of their patients, they are expected to either provide or arrange through referral all services that are of benefit. Since physicians are paid for each service they provide, the incentive is to provide more services. It has been suggested that this incentive, inherent in any fee-for-service payment system, may be magnified when physicians face constraints on their fees or competition for patients.

For example, the substantial growth in physician supply, particularly in the past ten years, would have been expected to increase the number of services used as a result of making care more available. Some have argued, however, that physicians may have compensated for a decline in average patient load resulting from the rapid increase in their numbers by increasing the number of services they provide per patient. The potential for such a response is certainly there, with the financial incentive to add an extra service or test, the uncertainties in medicine about whether the extra care will benefit the patient, and concerns about professional liability.

Beneficiary demand for care also contributes to increased service use. Strong media interest in advances in medical care affects Medicare beneficiaries as well as the rest of the population. They have high expectations. Moreover, fee constraints and rising assignment rates, in conjunction with supplementary coverage (Medigap), have reduced some financial barriers to seeking care. While the primary goal of both physicians and beneficiaries is providing care that will benefit the patient, decisions about the use of any service that is perceived to have some potential benefit will be influenced by both the positive financial incentive for physicians to provide the service and the weak financial incentive for beneficiaries to restrict their use of services.

THE WORK OF THE COMMISSION

Congress created the Commission to advise it on the reform of Medicare physician payment. The Commission is committed to bringing recommendations to Congress next March that include a fee schedule for Medicare and a strategy to restrain the growth in outlays for physician services that does not adversely affect quality or access to care.

A fee schedule is intended to correct deficiencies in the current "customary, prevailing and reasonable" (CPR) payment method that are generally recognized by all parties affected by Medicare policy. A fee schedule will be less complex and easier to administer than the present system. It would introduce much-needed national uniformity into the implementation of program policies. It also would reduce distortions in financial incentives for how physicians practice, where they locate, and what specialty they select. The goal of a fee schedule is to make these incentives as neutral as possible so that patient care decisions will be determined by medical considerations with little influence by financial factors.

A fee schedule based on the resource costs of providing physician services is likely to encourage more appropriate choices about which services are provided to patients, but it generally retains the incentives for overutilization inherent in fee-for-service payment methods. While it would represent a significant improvement over the current payment method, a fee schedule alone will not control the costs of physician services sufficiently, nor insure that patients receive the services most appropriate for their needs. We will also need more direct measures that focus on selectively reducing services of least benefit without threatening the many valuable services for which Medicare pays.
The challenge before us is to control the rapid growth in service volume not by reducing access to necessary care but through measures that assure more appropriate provision of services. As you, Mr. Chairman, and Congressman Gradison noted in a letter to the Commission last year, it is a "tall order" to come up with effective policies that neither threaten financial protection for Medicare beneficiaries nor compromise their access to needed health care. And, while current budget constraints make it all the more compelling to provide care in the most cost-effective manner, we should not lose sight of the fact that paying for services that have little or no medical benefit, and may even risk harm to the patient, is not money well spent under any circumstances.

This is not just an issue for Medicare. It must be addressed by employers who self insure or provide health insurance for their employees, by private insurers and by organizations representing the consumers of medical services. But, first and foremost, it is an issue that must be addressed head on by the medical profession. It is not an easy issue. Many have been working on possible approaches to abating the continuing increases we see, but there are no simple solutions.

In the Commission's last report to Congress, we described several underlying requirements for a strategy to meet the dual goals of controlling volume growth and maintaining access and quality:

- First, Medicare beneficiaries and their physicians must be willing to forgo services of little or no benefit.
- Second, all parties -- physicians, beneficiaries, and others who influence medical choices -- must have more usable and complete information about the effectiveness of alternative medical services.
- And third, there must be incentives to use such information to eliminate unnecessary or minimally beneficial care.

I would like to describe to the Subcommittee the Commission's work on two approaches that together may meet the criteria for a successful strategy: the development and use of practice guidelines and expenditure targets.

PRACTICE GUIDELINES

There is increasing evidence that beneficiaries receive services that are unnecessary and fail to receive some services that would benefit them. Over many years, a substantial research literature has documented unnecessary laboratory tests, radiological procedures, hospital admissions and days of care, surgical procedures, and drugs. Several recent studies of specific procedures have shown that as many as 10 - 30% of recipients were unlikely to benefit because the procedures were performed for inappropriate reasons.

These inappropriate procedures reduce the quality of care and increase cost. Inappropriate invasive procedures may involve substantial risks to the patient without accompanying benefit. The cost of these unnecessary services is also substantial. For instance, Medicare spends more than $300 million per year on physicians' charges for coronary artery bypass operations. If just ten percent of these are inappropriate, $30 million in physicians' charges and millions more for the associated hospital charges could be saved or spent for more beneficial services.

Substantial variation in the use of services among geographic areas has been documented for hospitalization and for many procedures. For instance, Wennberg has shown per capita variations as great as six-fold among communities in New England in the use of procedures like hysterectomy and prostatectomy. Chassin and colleagues demonstrated similar variations in the use of many procedures for larger areas.

Scholars have attributed much of the geographic variation and the use of unnecessary services to uncertainty among physicians as to what services are appropriate for their patients. In some cases, even the experts do not know whether a procedure is likely to be effective -- not enough information is available because the clinical research to fully determine the risks and benefits of the procedure has not been done. In others, the information is available in the research literature, but many individual practicing physicians may not have that information.

Incomplete knowledge of the risks and benefits of medical services and procedures also limits the effectiveness of utilization and quality review. Review criteria are not always based on sound evidence, with the result that much review is open to the criticism that it is arbitrary and inhibits good quality care. The Commission would like to see review of utilization and quality be based more on knowledge of appropriate medical practice.

There are two ways to increase what we know about the risks and benefits of medical services: clinical research on effectiveness, and development of practice guidelines that draw on this research and on the clinical experience of practicing physicians.

Practice guidelines are essentially clinical recommendations for patient care. They provide guidance to physicians and others who must make decisions about the use of specific medical services. Formally developed guidelines provide a way to synthesize existing clinical knowledge, extend it through the consensus of expert physicians, and make it available in usable form.

Practice guidelines are not new. They have long been used to provide clinical information to physicians. Examples include protocols for diagnosis and management of cancer and recommendations for the use of preventive services such as mammography screening. But there has been a recent increase in development of practice guidelines for a variety of medical and surgical procedures.

Several specialty societies, including the American College of Physicians, the American College of Cardiology and the American College of Emergency Physicians, have developed practice guidelines in the past several years. Other specialty societies have recently begun projects to develop them as well.

The federal government has an important role to play in laying the groundwork for higher quality and more efficient care, both through support of clinical research and encouraging the development of practice guidelines. It seems clearly appropriate for the federal government to support additional clinical research to develop our knowledge of the effectiveness of medical practices. The work needed to evaluate and refine the methods to be used to develop practice guidelines -- the next step in the process -- could also be conducted with federal support.

Federal funding would also be required if there is to be a substantial effort to develop guidelines themselves, but it is not yet clear what the precise role of the government should be in this area. The government could mobilize the resources to develop guidelines or it could contract with others for their development. Alternatively, it could convene groups within the medical community and sponsor development of guidelines in cooperation with the medical profession, an approach that is likely to be more acceptable to physicians. The government could do this through an intervening body such as the Institute of Medicine, the Joint Commission for the Accreditation of Healthcare Organizations, or a consortium of academic health centers. The scientific traditions of the NIH and its perceived distance from the government as payer would make it possible for NIH to play this role.

The Commission will host a conference on practice guidelines in Washington on October 11 to discuss questions about how guidelines should be developed and used, and what role might be most appropriate for the federal government. We expect the conference to help the Commission and others develop a sound strategy for the development and use of guidelines.

EXPENDITURE TARGETS

Under a system of expenditure targets, updates of physicians' fees in an area would be adjusted on the basis of how total expenditures compared with a predetermined target. If the physicians in an area effectively controlled the volume of services in that area, they would receive the full scheduled increase in fees (perhaps, even more). The intent of expenditure targets is to have the physician community take responsibility for the appropriate use of medical services, and to rely on the medical profession to develop or support specific measures to accomplish this.

Expenditure targets may provide a means for controlling Medicare program costs by creating incentives for physicians in a defined geographical area to work together to reduce unnecessary, ineffective and inefficient use of medical services. They also could bring beneficiaries a lower rate of increase in the Part B premium and in coinsurance liability, even if physicians did not respond by slowing increases in the volume of services. And, for taxpayers, expenditure targets could slow the rise in Medicare program costs.

In its last report to Congress, the Commission described a number of issues related to the feasibility and design of expenditure targets. We have continued to look closely at those questions since that time, and the Commission will begin to consider the options at its meetings in October and November. I want to focus for a moment on the issue that is perhaps the most difficult and the most crucial.

The impact of expenditure targets on service use will depend heavily on the willingness and ability of physicians as a group to respond constructively to this collective incentive to reduce inappropriate services and thus to moderate expenditure growth. For the system to result in more appropriate use of services, the physician community must develop responses that affect the behavior of individual physicians. The assumption underlying expenditure targets is that placing physicians collectively at risk could lead to stronger collective interest and participation by the profession in the development of practice guidelines, physician education and effective utilization and quality review. The Commission is exploring whether and how effective physician involvement in administering the expenditure target could be ensured. It is developing a series of organizational models that range from modest changes in the current Medicare review system to more fundamental restructuring that places greater responsibility on the medical profession.

For expenditure targets to be a successful tool for increasing the appropriate use of services, they must be more than a formula for determining fee updates. They must establish both a structure and incentives for physicians to assume greater responsibility for the effectiveness and efficiency of the care they provide. Expenditure targets are likely to have a positive effect on patient care as well as program costs only if the physician community considers them a legitimate means to a reasonable end. This in turn depends on two conditions. First, the targets have to be economically reasonable. Second, physicians reimbursed by Medicare have to be involved in the development and administration of the utilization and quality reviews, and committed to making the reviews productive.

The Commission's work is proceeding in several areas in addition to our effort to define an appropriate organizational structure and roles of various participants (e.g., medical societies, PROs and carriers). They include:

- specifying such technical features of the policy as the geographic unit to which the targets would apply (e.g., states, metropolitan and nonmetropolitan areas) and the expenditures to be included in the target (e.g., Part B only or Parts A and B combined)
- developing appropriate administrative structures and systems to carry out the expenditure target policy (such as timely data reporting)
- examining the feasibility of exempting organizations of physicians which meet expenditure goals through other mechanisms from the general expenditure target, and
- defining necessary processes and mechanisms to insure accountability of the system.

Because the physician community must have adequate time to respond constructively to the new responsibilities it could assume under a system of expenditure targets and it will take some time to put in place the systems to support both setting targets and monitoring practice patterns, full implementation of expenditure targets could not be accomplished quickly. The Commission is exploring alternative implementation strategies that provide credible incentives to stimulate a constructive response from physicians and yet are sufficiently gradual to permit the development of a structure that will assure the effectiveness of the policy over the long term.

CONCLUSION

Sound policies must be developed that will reduce the rate of increase in Medicare spending for physician services while maintaining access to high quality care for Medicare beneficiaries. Those measures must focus on selectively reducing services of least benefit, by providing both better information on the effectiveness of medical services and greater incentives to use that information. The Commission is assessing the potential of practice guidelines and expenditure targets together to provide a strategy that will moderate Part B spending.

Chairman **Stark**. Thank you, Phil.

Mr. Gradison?

Mr. **Gradison**. Dr. Lee, do you think it would make sense and be at all realistic if we were to turn to an umbrella organization representing physicians, like the American Medical Association, and indicate, for example, that next year we can put 10 percent more dollars into this program, and give them a printout of the number of procedures in each category that we anticipate, based upon recent trends? Would it be realistic to ask them for their suggestions as to how to set the prices for each of those procedures so that they would multiply out and come reasonably close to that, say, that ten percent.

I mean, I do not think we can delegate legally, truly, some of these determinations, but as you can tell, I have been trying to figure out ways to involve the private sector in this. And if there were a group on the outside that could take these data and come back with recommendations to us, and then they were written into regulation by HCFA or the statute by us for a year, it would just seem to me it might, again, remove—maybe it would be abrasive from the AMA's point of view versus its members, but it might be less abrasive from our point of view versus the medical profession.

Dr. **Lee**. We see three options for this update. One is that kind of negotiation with the medical profession, where they would play the primary role in that determination. A second would be where you would have an independent review body, such as the Commission, where both HCFA and the AMA or other representations of medicine—but I think your comment about the AMA, there has to be some group to represent medicine, and the AMA certainly seems to be the logical choice to do that—they would make their presentations, and then that independent review commission would recommend to the Congress.

A third is the present approach where HCFA basically arbitrarily makes those determinations with some guidance from the Congress, which we think is the most adversarial approach possible.

So we believe either the approach that you suggested or this independent commission makes sense. If you had an expenditure target, you could then move to that approach. With the present system, where it is open-ended, where you have no cap on expenditures, it would be, I think, more difficult to assure that you would not continue to have these very inflationary increases that we have seen in the last 10 years.

Mr. **Gradison**. Thank you.

Chairman **Stark**. Mr. Coyne?

Mr. **Coyne**. Thank you, Mr. Chairman.

Dr. Lee, what do you and the Commission feel about Medicare's ability to implement a new fee schedule plan without affecting the access and quality of care to the beneficiary?

Dr. **Lee**. The key question, of course, is if you take the resource-based relative value scale, the key question for us is beneficiary access and impact on costs. And if you suddenly lowered fees in certain—let us say for cataract surgery, would there be an increase in the extra bill or balance billing for the beneficiary to receive that service? Or would the patient be, in a sense, denied that service because they could not meet those extra billing requirements or balance billing requirements?

That is very much a concern to the Commission, and I am not just talking about cataract surgery. We were talking about other services as well.

In our evaluation of the development of a resource based relative value scale which would be the basis for the fee schedule, we will be very carefully examining that issue. We will be doing simulations on the impact of a change not only on every specialty group, but on beneficiaries as well. So we will have some knowledge, before we make a recommendation to you, about what the impact will be.

Second would be a transition period of perhaps a minimum of 4 years from the first implementation to full implementation so that it would moderate that impact over time.

A third thing that you need to do is to monitor very carefully the impact. We will be discussing at the Commission hearings next week the development of such a monitoring system so that we can have a better method of monitoring access to care for beneficiaries. We think this is necessary if you are going to move to any kind of new payment system.

Mr. **Coyne**. So the resource-based relative value scale does account for access and competency?

Dr. **Lee**. Well, it potentially can improve access. But as with any change, you can have some negative consequences. And we want to try to do sufficient analysis before we make recommendations to you next spring to know what those negative consequences might be, particularly with respect to access and to increased cost-sharing by beneficiaries, if we can make those estimates, as well as any potential beneficial effects on costs and quality.

Mr. **Coyne**. Thank you.

Chairman **Stark**. Mr. Moody?

Mr. **Moody**. Thank you.

Doctor Lee, you heard my exchange with Dr. Roper on several issues. One is the elasticity of volume with respect to the price of the services. Surely that is so crucial an issue. Do you know the research and what the research shows on that?

Dr. **Lee**. Well, there have been conflicting results, and I think that Dr. Roper's commitment to provide you with a careful analysis of the literature would be the best answer. But there have been some studies that have shown—for example, in the Medicaid program in California, when prices were reduced, volume was increased, not necessarily with the same services but perhaps with other services. In other words, physicians were able to make up with a volume increase for the price reduction.

I believe that study was done by Jack Hadley and John Holahan at the Urban Institute, and I think they have different conclusions about the results of the study.

Mr. **Moody**. The two of them do not agree on the results?

Dr. **Lee**. I believe they do not agree on the conclusions. I think they agree on what happened, but I am not sure they agree on the conclusions.

Mr. **Moody**. Obviously, one of the models must have been that physicians have a kind of target income.

Dr. LEE. One of the hypotheses is the target income hypothesis. And one of my colleagues, Hal Luft, who is an economist, has looked at that recently in California a few years ago. He found some support for that hypothesis; but the results are not clear cut.

Mr. MOODY. Did both researchers and does other literature support the theory that increase in volume demand is doctor driven? Or is it, as the AMA's testimony apparently suggests, patient-driven?

Dr. LEE. Well, certainly if you——

Mr. MOODY. There is some evidence of both.

Dr. LEE. That is correct.

Mr. MOODY. But what is the dominant force of the two?

Dr. LEE. Well, it depends on the service that is provided and at what level. For example, there are certain services that are clearly entirely doctor determined. There are other services where there is patient demand: use of drugs, for example, or use of tests. Some of those things, patients will come in and they will ask for it—or their condition calls for it in a sense. Let us say a person comes into the doctor with high blood pressure. That necessitates certain things being done if you want to provide a good standard of care.

You could say, well, is that doctor induced or is that patient-induced demand?

Mr. MOODY. Where there is discretion.

Dr. LEE. Where there is discretion, there is clearly a significant factor that is doctor induced, and one of the areas, as I indicated in my testimony, we are concerned about is the appropriateness of care. In many cases, inappropriate service use is due to the doctors not being adequately informed, that we do not have standards yet established as to what should be done in a particular situation.

So it is not necessarily a doctor seeking a target income; it is simply a doctor doing what he thinks is right, but he does not have the proper information.

Mr. MOODY. That is a pretty bitter pill to swallow, would it not be, for the medical profession, to agree to stipulate to that conclusion? You are almost saying incompetence, are you not?

Dr. LEE. No, I am not saying that at all. Medicine is both an art and a science. And if you just think about the care of a terminally ill patient, what is done for that patient, there is a great deal of judgment involved in that in terms of what a particular doctor will do with a particular condition, and what the patient may want in that particular situation.

One patient may want to be in an intensive care unit. He or she may request that. The doctor will say, all right, we will do that. We will see what we can do.

In another case, the patient may say, well, I want to be in a hospice, or I want to be at home.

So you will have that interaction, and it is not at all incompetence. It is a matter of there being a tremendous judgment area where we do not have really sound, scientific evidence as to what is appropriate.

Mr. MOODY. Of course, in that case of terminal illness, the patient's last requests bear an unusual amount of weight, where cure is not so much the issue but, rather, in what setting the patient wants to die.

Getting back to your earlier point about lack of information, the hospice is not an example of lack of information, is it? It is more of a judgment call; is that correct?

Dr. LEE. A hospice is a matter of judgment call. But in many areas, we have not done the kind of longitudinal studies needed. As we do research, we find that some procedures that we formerly thought were beneficial, or some people thought—for example, Owen Wagenstein, who was a very famous professor of surgery and chairman of surgery at the University of Minnesota, one of the leading surgeons in the United States, came up with the idea that gastric freezing was a good approach to the treatment of ulcers. Well, that became very popular because Dr. Wagenstein recommended it. When studies were subsequently done, it was found to be a very ineffective approach.

When I was a resident, one of my professors was advocating cabbage juice, and on our service we were giving patients large amounts of cabbage juice. Well, this was later proven to be ineffective.

So we have had many treatments that have been discarded over time that were thought to be effective treatments. And I am sure some of the things we are doing today will be discarded next year and 5 years from now. That is without any negative comment about the individual physicians involved in those cases.

Mr. MOODY. All right. But when you say large amounts of misinformation or lack of information, that applies to something that we can correct by providing information, right? You do not alter the price system for that problem, do you?

Dr. LEE. That deals with the appropriateness question. Is the care appropriate? And we can improve the appropriateness, I think, through those practice guidelines and through feedback to the individual doctor, so that the individual doctor knows that he or she is deviating from the norm. And we have got to have a mechanism for doing that, and so that other physicians can work with the individual doctor in an educational setting to correct those practices.

Mr. MOODY. This seems so desirable. What is the inhibition of doing this now?

Dr. LEE. Well, I think there is a big movement now to do it. That is one of the reasons we are holding this conference. The College of Physicians has worked in this area. The American College of Cardiology has taken the lead. A number of the professional groups have very aggressively taken the lead in this area, and I think we will see rapid progress in the next 5 years.

I think there has been great reluctance within the medical profession to tell another doctor what to do. We will tell you when you are a med student or a resident, but when you are out in practice, there is great reluctance, you know, to tell other doctors what to do.

Mr. MOODY. Let me just move for a second to expenditure targets. How are those being enforced? You make a strong case for them, but other than exhortation, what do we do to enforce them or build in the correct incentives so that we arrive at those expenditure targets without simply cutting off access or sharply reduce the quality?

Dr. LEE. We hope to be able to answer that question by next spring when we give you our report. We are looking into that. What are the implementation issues with respect to expenditure targets? Should it be on a State basis? Should there be an expenditure target for California, for New York, for each State? And within that State, then, the medical profession would take this responsibility. There you have got State medical societies that are in some ways very good vehicles, potentially, for doing that. Should it be on a sub-State basis? I mean a smaller geographic area. Perhaps it should be.

We need to look at that in terms of how do you monitor that and how do you control that? We are just beginning to explore that in the Commission and in the Commission staff.

Mr. MOODY. And these are part B expenditure targets?

Dr. LEE. These are part B expenditure targets. You could do it for both, part A and part B, potentially.

Chairman STARK. Would the gentleman yield?

Mr. MOODY. Sure.

Chairman STARK. It is my understanding that Dr. Lee has to leave us at 4 o'clock, but I would be glad to have him come back.

Mr. MOODY. No, that was my last question.

Chairman STARK. Mr. Pickle would like to inquire.

Dr. LEE. We can also, Mr. Chairman, answer any questions in writing that Mr. Moody would want to address to the Commission staff.

Chairman STARK. Sure.

Mr. MOODY. No, that was my last question.

Dr. LEE. We would be very glad to do that.

Mr. PICKLE. Well, I thank the gentleman.

Dr. Lee, as I understand it, your Commission has not made any recommendation about the controls under the part B. You are still studying it, and you hope to get it out by next spring?

Dr. LEE. Well, on the fee schedule—we made, of course, some recommendations to the Congress last year on the over-valued procedures. Congress accepted those recommendations. So we have made some recommendations that I think have been useful in moderating the rate of increase in expenditures under part B. But we have not made a recommendation on a fee schedule.

Mr. PICKLE. Well, Mr. Gradison had asked you earlier what you thought about just allocating a certain amount of money on Medicare, whether it is a 5- or 10-percent increase, and then say that is all we are going to spend and let the physicians set those fees. And I think that is an appropriate question to ask.

As I understand it, you said you are going to study that, and you are all going to be meeting next week, I guess, or next month.

Dr. LEE. We will be having hearings every month until we report to you next spring.

Mr. PICKLE. And I assume what Mr. Gradison is saying is that in Canada they, in effect, do that, and that system works in Canada. My question to you is: Do you think that type of system can work here in the United States?

Dr. LEE. I think that the fact that in Canada, in my opinion, the physicians are given much more responsibility, and there is much less direct regulation of physicians—is the way we should go. It is the direction we should move. I think the medical profession should be given much more responsibility for regulating the profession. I think we have too many people regulating what doctors do now, and I think that if we could find a way to permit the medical profession to do that itself, we would have more effective regulation than we have today—which I do not think is very effective.

Mr. PICKLE. But I think we agree generally that is correct. Now, the question is: How can that be done, or can it be done? On the one hand, Canada, in effect, does it. And I guess the argument is that the Canadian provinces are strong; they are much stronger than the local entities. The physicians are not as well centralized or specialized and organized there as they are here. And when they set the fees, they say that is it. They can control it.

Do you think that our physicians will be that passive or quiet or cooperative?

Dr. LEE. The biggest difference in Canada and the United States is that in Canada there is a single payor. So it is the whole ball of wax. Medicare is only 20 percent of doctors' incomes. So even if you have an expenditure target and you do this negotiation with Medicare, it only is going to affect a certain percentage of the doctor's income.

I do not think the doctors in Canada are passive. I think they have more power than the doctors in the United States. You know, I think that they control licensure, they control discipline, and they control the fee schedules, as Mr. Gradison has pointed out. As a matter of fact, the fee schedules that were originally adopted in most provinces were what the physicians had decided in their own insurance programs, which were very similar to Blue Shield. They had similar insurance programs that covered, in some provinces, as many as 80 percent of the population before there was national health insurance in Canada. The Government simply adopted those fee schedules, and then with the updates each year it is the physician who decide which fees go up, which fees stay the same.

Mr. PICKLE. Well, I want to see the kind of proposal that would show me who makes these controls, who decides what the level of payment is going to be. How do we get our physicians together? Is there a commission or a group that can come together and say: We speak for the physicians?

It is interesting to say we might implement that type system, but I am trying to say how do you do it? How can you get people to come together?

Dr. LEE. Well, that is the key question within the medical profession, and I would say that certainly the AMA is the most logical group to represent the physicians in those negotiations.

Mr. PICKLE. All right. Now, earlier on one other question with respect to guidelines and standards, have you made a recommendation, your Commission, on that?

Dr. LEE. The practice guidelines?

Mr. PICKLE. Yes.

Dr. LEE. Not yet, but we will make recommendations in our report next spring. We are moving very rapidly in that area. This October meeting will be very helpful. And we certainly will be making recommendations in our spring report to the Congress with respect to practice guidelines and how they might be used in the Medicare program.

Mr. PICKLE. Were you here when I asked Dr. Roper a few minutes ago about why they used the 1980 census for hospitals with respect to the question of urban and rural?

Dr. LEE. I was here when you asked that question, and I cannot answer the question.

Mr. PICKLE. My question to you is: Were you here when I asked that question?

Dr. LEE. I was here when you asked the question.

Mr. PICKLE. And I will pose the same question to you. What is your answer?

Dr. LEE. Why do they use it?

Mr. PICKLE. Yes.

Dr. LEE. I do not know why they use the 1980 data.

Mr. PICKLE. Dr. Ginsburg, you looked anxious. Are you trying to say something?

Dr. GINSBURG. We have not looked too closely into the details of the hospital payment, being the Physician Payment Review Commission. ProPAC is the one that specializes in that, and I would rather not try to answer that question.

Mr. PICKLE. Well, I wonder if Dr. Roper is still around.

Dr. LEE. I think he had to leave.

Mr. PICKLE. I am going to have a letter off to him today to try to give me some reason for it. As I understood a few minutes ago, he said we do not always use the 1980 census, but it does in this instance. Eight years old. And I do not understand that at all. But I know that is not your responsibility, but I was just anxious to know if you would express yourself, and I understand.

I thank you.

Chairman STARK. Mr. Levin?

Mr. LEVIN. Let me just ask you, if you might, sum up. Based on all of your vast experience, what is your guess as to the odds that we could come up with a meaningful, comprehensive system of expenditure targets in this country? As you go into your further hearings, a lot of the questions have related to that, and it is so appealing on the surface. In practical terms, as you go into this, without prejudging the best way and all that, how optimistic are you that we could carve out a meaningful system in this country?

Dr. LEE. Well, I would say that several members of the Commission—Uwe Reinhart, who is an economist, and myself are probably more optimistic about this area than maybe some other members of the Commission. I think there are some members who are quite skeptical about the possibility.

I believe that it will be possible if we look at the experience of other countries, which is somewhat relevant—you know, there are lots of things here that are different. But I believe it will be possible in our April report or in our March report to come up with some specific recommendations with respect to expenditure targets and how those might be implemented when a new fee schedule is developed. I think those have to go hand in hand.

I think that that can be done. I think it would be implemented over a period of time. I do not think it would be, you know * * * you do not go out of the gun all at once. It might even be that you would have some large scale demonstration projects in that regard. I do not at this moment have a judgment about that. But I believe it will be feasible for us to make some clear-cut recommendations to the Congress with respect to expenditure targets.

Mr. **Levin**. Well, good luck.

Dr. **Lee**. We will do our best.

Mr. **Levin**. You always do that, and better. Thank you.

Thank you, Mr. Chairman. That is good news.

Chairman **Stark**. Phil, is the number one priority of PhysPRC to reduce the aggregate amount or the rate of increase of Part B physician services?

Dr. **Lee**. I would say that perhaps even more important we want to assure the continued access of the beneficiaries to appropriate medical care. And I think if you do that, you then will be able to reduce aggregate expenditures, because I think there is a significant amount of inappropriate care being provided.

Chairman **Stark**. Let us go back a minute. At some point you have got to choose up sides. The AMA has been gaming us that way for years. We talk price, they talk quality. They think they are running the A&P.

The point is that we will not tolerate second-rate quality, even if we get pushed into legislating jail sentences for physicians who practice second-rate medicine.

We are going to hear talk of factors from the AMA about why costs go up. They are going to talk about aging and shifting to outpatient services and increased demand by the patients. The question is, the fees that Medicare has charged have gone up in the aggregate 15 percent, and recently 12 percent. At the same time, in a parallel way, the net income of physicians has gone up the same amount. So you have got a pot of money that comes out of the Treasury, and for whatever reason, it finds its way through this maze and ends up in the pockets of the doctors.

I am not suggesting that we are going to cut back on this. I am just saying that a 12-percent increase is unacceptable.

Dr. **Lee**. That is too much.

Chairman **Stark**. And it has to mean that doctors' incomes cannot increase at the same rate.

Dr. **Lee**. I could totally agree with that.

Chairman **Stark**. OK. So, there is nothing lost in that system.

Dr. **Lee**. Well, Bill Roper last year testified about value for service, and he had an article in Health Affairs where you have to put cost——

Chairman **Stark**. Well, let me just come back to that.

Dr. **Lee**. Cost has got to be a factor.

Chairman **Stark**. All right. But, look. If the Government is going to spend less, that means the doctors in the aggregate are going to have a smaller increase.

Dr. **Lee**. A lesser rate of increase. Absolutely right.

Chairman **Stark**. All right. Now, it would seem to me that the AMA is the only group that I know of that represents maybe half the doctors, kind of an umbrella group, and I don't think they do a very good job of it. But let us suppose that they continue their practice in the past and refuse to negotiate. What do we do then? Who is the second group? Do you want to do it?

We attempted to negotiate with some subspecialties last year. We did so, effectively. The AMA sandbagged it. They fought it, politically won.

If you have a group that refuses to negotiate, things become very difficult.

Now, who is your second choice, assuming they do not want to play?

Dr. **Lee**. Well, if the AMA—whatever process you choose, let us say you do the expenditure targets.

Chairman **Stark**. Whatever process.

Dr. **Lee**. But that is the way you set a limit on your expenditures so that you are not going to have the price increases. If the medical through AMA refuses to negotiate about what the prices should be and what the utilization control should be, you then have to seek out another umbrella group to bring together the various specialists—family practitioners, surgeons, and——

Chairman **Stark**. So what you are saying is that if the AMA does not want to play, we do it a specialty at a time.

Dr. **Lee**. We have to create a consortium that would reasonably represent the medical profession to accomplish that.

Chairman **Stark**. I understand that. As I say, we can do the hospital route. I do not think any of us really think that DRG's for physicians is a very good process. But in the absence at some point of any other way, we just might have to say how we are going to spend. I do not know quite how you do that, but I am afraid it would be a lousy system.

I think as long as everyone who is party to this attempts to understand that the Government wants to have a lower rate of increase, and that means a smaller rate of increase in doctors' incomes. Doctors do not have to be branded socialists for saying we are not going to pay them three times the average increase that we pay to Federal employees. It is not because we do not like doctors. It is just because the taxpayers and the beneficiaries are going to be unhappy if we do not.

Do you feel that the physician community absolutely is willing to participate in that?

Dr. **Lee**. I do. I think that Jim Todd can maybe give you an answer. That is a personal view, obviously, and it is a not a view representing the Commission. But I believe they definitely would do so.

Chairman **Stark**. And if we decided that part of it was going to be increased emphasis on capitation, do you think they would participate in those negotiations?

Dr. **Lee**. Well, if you look at what is happening now, if you think about managed care systems, the great majority of physicians are now in one form of managed care system or another. Business is promoting this very, very aggressively through both self-insured employers and through various other insurance arrangements. And they are participating in those very actively, very aggressively. And I would say that the Government is quite a ways behind the private sector with respect to managed care at the present time.

Chairman **Stark**. I understand that.

It is 4 o'clock. There is a vote, and you have to catch a plane.

Dr. **Lee**. I do, indeed.

Chairman **Stark**. I appreciate it very much. I hope we have a chance to meet with you informally after the election. Thank you again. We appreciate your being here, and we will talk to you soon.

Dr. **Lee**. Thank you.

Chairman **Stark**. Thank you very much.

The committee will recess for 5 minutes.

[Recess.]

Chairman **Stark**. Our next witness is Dr. Janet Mitchell, the president of the Center for Health Economics Research.

Dr. Mitchell, welcome to the committee. We have your prepared testimony, and it will appear in the record in its entirety. If you would care to summarize or highlight your testimony, it would be appreciated. Proceed in any manner you are comfortable.

STATEMENT OF JANET B. MITCHELL, PH.D., PRESIDENT, CENTER FOR HEALTH ECONOMICS RESEARCH, NEEDHAM, MA

Ms. **Mitchell**. Thank you, Mr. Chairman. I would like to thank the committee for inviting me here today.

I am happy to be able to share some very recent research findings with you today. As you of course know, despite the fee freeze, the Medicare program has seen its total outlays continue to increase.

Now, Medicare enrollments have also been going up, but this explains only a small part of increased spending. If prices are frozen, then expenditures can go up only if the volume of services is increasing, or if physicians are providing a more expensive kind of service.

For policy purposes, it is very important to understand how spending on physician services has increased. Knowing which services have been growing disproportionately may help you target reimbursement reforms more efficiently and more equitably. Is it office visits that are going up? Is it surgery? Is it x rays? Is it lab tests? Basically, where has the money been going?

In order to study trends in physician spending, I analyzed Medicare Part B physician claims from four States for the period 1983 through 1986. Part B physician spending per beneficiary increased steadily over this 4-year period, even during the period in which fees were frozen for all physicians, which was July 1984 until May 1986. By 1986, the Medicare program and its beneficiaries were spending 30 percent more for physician services than they had three years previously. This amounted to a $132 increase for every Medicare enrollee.

Although spending increased for all types of physician services, three kinds of services increased at above average rates. These were surgery, radiology, and specialized diagnostic tests like ECG's, echocardiography, cardiac stress tests and the like.

Increased spending on surgical services was the single most important factor, accounting for 40 percent of the growth in Medicare outlays on physicians.

Just two procedures, cataract surgery and colonoscopies, accounted for one-third of the increase in surgical expenditures, and for over one-seventh of the increase in total physician spending. Other operations whose volumes were growing disproportionately during this time included coronary artery bypass graft surgery, cardiac catheterization, upper GI endoscopy, and total knee replacement.

Many of these procedures, I might add, have been subject to rollbacks this past April on the grounds that they were overpriced to begin with.

Now, while the volume of surgical operations, x rays and diagnostic tests has been rising, the number of physician visits per beneficiary has remained fairly constant. The mix of visits has very definitely changed. There were fewer hospital visits and more office visits, but the total number did not really change.

Nevertheless, spending on these visits still increased considerably, and the reason for this was a relabeling of visit codes from simpler to more complex ones, the more complex ones being more expensive.

While spending on physician services was going up, it was not increasing at equal rates for all physician specialties. Spending grew far more slowly for primary care physicians, like general and family practitioners and internists, and it grew much more rapidly for specialists, such as cardiologists, gastroenterologists, thoracic surgeons and ophthalmologists.

What do these volume increases imply for physician payment reform? Well, for one, I think it is noteworthy that the increases took place generally among services that are physician-initiated rather than patient-initiated. Physicians recommend surgery and diagnostic tests, for example, but it is often difficult for patients to evaluate the appropriateness of these services.

Second, my results underscore that if you want to control costs, you must control the number of services provided. Simply tinkering with the prices will not do the job.

I think that the most effective way is to give physicians an incentive to control their own utilization, and one way in which this could be done is through the packaging of physician services. An example would be to pay a fixed rate for an episode of care that encompassed both visits and diagnostic tests and procedures.

Thank you.

[The statement of Ms. Mitchell follows:]

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STATEMENT OF JANET B. MITCHELL, PH.D.
before the
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

September 29, 1988

Introduction

My name is Janet B. Mitchell. I am the President of the Center for Health Economics Research, a non-profit research firm in Needham, Massachusetts. I would like to thank the Committee for inviting me here today and giving me the opportunity to share some new research findings with you. Much of my research during the past decade has been devoted to physician reimbursement under Medicare and Medicaid. Most recently, I have been studying the trends in Medicare physician spending during the fee freeze.

Despite the fee freeze imposed by Congress from July 1984 to May 1986 (and to December 1986 for nonparticipating physicians), the Medicare program has seen its total outlays continue to increase at double-digit rates. Of course, Medicare enrollments are also up, but this explains only a small part of increased spending. If prices are frozen, then expenditures can go up only if volume is increasing, i.e. if physicians are providing more services, or if they are providing a more expensive kind of service, e.g. longer, more comprehensive visits, or CAT scans instead of more routine x-rays.

For policy purposes, it is very important to understand how spending on physician services has grown during a period of frozen fees. Knowing which services have been growing disproportionately during this time may help target reimbursement reforms more efficienctly and equitably. We may never know exactly why expenditures have continued to increase, however. The last five years have been a period of tremendous change in the way physicians care for patients and in how Medicare reimburses that care. Besides the fee freeze itself, there were three other major changes:

(1) implementation of the Medicare Prospective Payment System, which has shifted the locus of care from inpatient to outpatient settings;

(2) introduction of the Medicare Participating Physician Program, which has raised assignment rates; and

(3) implementation of the direct billing policy for lab services, which prevents physicians from billing for any lab tests they do not personally perform in their office.

Some unique primary data were assembled in order to study trends in physician spending during the period of the fee freeze: Medicare Part B claims from four states for four years, 1983-1986. The four states were Alabama, Connecticut, Washington, and Wisconsin. They were chosen because they represent the four major geographic regions and because they all shared a common procedure coding terminology (CPT-4) during this time period. All data were analyzed on a per Medicare beneficiary basis, so that any observed changes will have held increases in Part B enrollment constant.

Trends in Part B Physician Spending

Per beneficiary spending increased steadily over the four year time period, even during during the period in which fees were frozen for all physicians (July 1984-May 1986). By 1986, the Medicare program and its beneficiaries were spending 29.5 percent more for physician services than three years previously. This amounted to a $132 increase, up from $450 annually in 1983 to $582 in 1986.

Although spending increased for all types of physician services, three kinds of service increased at above average rates over this time period: surgery, radiology, and specialized tests.

- Increased spending on surgical services was the single most important factor, accounting for 41 percent of the growth in Medicare outlays on physicians.

- Just two procedures, cataract surgery and colonoscopies, accounted for one-third of the increase in surgical expenditures, and for over one-seventh of the increase in total physician spending. Other operations, whose volume growth has contributed disproportionately, include coronary artery bypass graft (CABG) surgery, cardiac catheterization, upper GI endoscopy, and total knee replacement.

- Greater spending on radiology services is also due to increased volumes, especially for more expensive procedures like CAT scans, as well as the advent of new technologies like magnetic resonance imaging.

- While specialized tests represent only 5 percent of total spending, they account for almost 11 percent of the increase. Volumes increased for both routine and rhythm ECGs, echocardiography, and cardiac stress tests, among other services.

There has been a dramatic shift of physician services out of the hospital and into outpatient settings over this four year period, a trend due largely to declining admission rates and declining lengths of stay under the Medicare Prospective Payment System (PPS). About two-thirds of the Medicare physician dollar was spent in the hospital in 1983, and it fell to less than one-half by 1986. By contrast, the share of Medicare spending in the physician's office rose from 29 to 33 percent, and the share spent on physicians in outpatient departments almost tripled (from 6 to 15%).

The shift from inpatient to outpatient settings occurred for all types of services, including physician visits. The average beneficiary had more office visits and fewer hospital visits in 1986 than in 1983. However,

- The substitution was totally offsetting; the total number of office and hospital visits did not change.

- Although the number of visits remained constant, spending on visits still increased 14 percent just during the 22-month period in which fees were frozen for all physicians.

The reason for this was a re-labelling of visit codes from simpler to more complex (and more expensive) ones. It is important to note that this does not necessarily imply fraudulent billing practices on the part of physicians; real casemix changes resulting from PPS as well as the ambiguous nature of the codes themselves undoubtedly are important factors.

While Medicare Part B expenditures per beneficiary were nearly 30 percent higher in 1986 than in 1983, the rate of increase varied considerably by physician specialty. Spending grew far more slowly for services provided by general and family practitioners (13%), by internists (17%), and by general surgeons (9%). Rates of increase exceeded 40 percent, however, for a number of specialists, including dermatologists, cardiologists, gastroenterologists, ophthalmologists, and thoracic surgeons.

- Surgery accounted for the majority of the increased spending for all of these specialists, except cardiologists. The growth in spending for cardiologists' services was due, in almost equal parts, to more visits and consultations, more diagnostic cardiac tests, and more cardiac catheterizations.

- Spending for gastroenterologists' services rose 73 percent from 1983 to 1986, with most of the increase due to two procedures: colonoscopy and upper GI endoscopy.

Conclusions

How can we explain such a large increase in Part B physician expenditures during a period in which fees were frozen for a large part of the time? Spending increased primarily because physicians simply performed a greater number of services, especially surgery, x-rays, and specialized diagnostic tests. It is noteworthy that these increases generally took place among services that are physician-initiated, rather than patient-initiated (like visits). Besides performing more services, physicians also increasingly performed more expensive kinds of services; this resulted both from technology diffusion as well as an upward shift in code mix.

These results suggest that effective cost control must seek to constrain the number of services provided as well as the prices paid. One way of doing this is through packaging physician services, i.e. redefining the payment unit from a specific procedure to a more comprehensive bundle of services. HMOs can be considered the ultimate kind of package in which all services, physician and hospital, are bundled together into a single capitated payment, but there are other less global alternatives. Diagnostic services might be packaged along with their associated office visits, for example. Not only would specialized tests, like ECGs, be candidates for such bundling, but also certain diagnostic surgical procedures like endoscopies. The major advantage to such packages is that they encourage the physician to take a broader view of the patient care process, with incentives to cut back on marginal procedures. Future research may help shed light on the feasability of such packaging arrangements.

Chairman **Stark**. Your last comment, what you are suggesting is something similar to the whole diagnosis. You lump all the costs together, like the DRG rate for hospitals. Is that it?

Ms. **Mitchell**. An example of packaging an episode of care would be packaging the entire inpatient episode and paying a physician or paying the medical staff a fixed rate. It would also be possible to consider packaging episodes of care on an ambulatory basis. Or an even more modest approach is simply taking a single visit and packaging with that visit the associated services that are provided with it.

The limited work that has been done in this area, most of which I have done, has not been particularly promising in packaging ambulatory episodes of care because we do not have the case mix classification systems definitions to adequately discriminate between them.

Chairman **Stark**. Would it be fair to characterize your testimony by saying that if there is an increased beneficiary demand, it is primarily in the lower cost services and has not created much of the aggregate increase in part B? You state that most of it is physician-initiated procedures, the higher costs, the major increase in costs. One would suspect that this does not go up. It is relative price inelastic.

Is that what I can conclude from your testimony?

Ms. **Mitchell**. Yes, there have been many studies of the price elasticity of demand for services. They all conclude that, yes, patients are sensitive to price, but the magnitude of their response is not very great. It also varies by type of service. And I simply do not think that you can attribute increases of 100 to 200 percent in the volume of certain services to patient demand.

Chairman **Stark**. Can you suggest anything to the committee that we could do? Let us just assume that we can put a dollar figure on the Hsiao study and that we will pay 50 cents a unit, so ipso facto, we have got a fee schedule. I understand your testimony to say that does not do it by itself because we will just have more procedures, and we will end up continuing to pay more money anyway.

What would you suggest if we get boxed into the fee schedule approach? What do we need to add to that to control aggregate costs?

Ms. **Mitchell**. Well, you could easily accompany a fee schedule with packaging of physician services. I think that that is something that some people have already begun thinking about because the services themselves vary around the country. When some physicians perform an endoscopy, for example, they do not submit a bill for the visit during which that endoscopy was performed. In other parts of the country, physicians routinely submit bills for that visit. So that change——

Chairman **Stark**. Excuse me. I do not know what that is. What I am assuming you are saying is to do an endoscopy, there is a certain price; and then the physician charges you for the office visit while you are there having this procedure performed in the office anyway. So it is kind of a double billing situation.

Ms. **Mitchell**. Some physicians do and some do not. It seems to vary considerably by the practice of the Medicare carrier and also by physician specialty. But, clearly, if you adopt a fee schedule that reduces the price of the endoscopy and increases the relative price of the visit, the incentive will be to increase the billings for visits.

Chairman **Stark**. Have you looked at the Hsiao study? Do you have a general idea what is in it?

Ms. **Mitchell**. Well, I have only seen the public presentations that he made last March.

Chairman **Stark**. That is all I have looked at.

Let me ask you this. This is a very pedestrian approach to it. But there are 3,000 line items in the Hsiao study, I gather, 3,000 procedures. Are you suggesting that someone with proper professional competence could say, OK, we are going to do an appendectomy? Then they could pick out of the Hsiao study the x ray that is needed, and this that is needed, and that that is needed, and put together a package and say that it totals 500 units? And if you do more x rays or more blood tests or something else, you still only have the 500 units. And it is a take-it or leave-it item.

Do you think that by itself this method would save us a good bit of money?

Ms. **Mitchell**. I think it has the potential to save money. Again, it is one of those kinds of programs that would probably be first introduced in a budget-neutral fashion with the hopes that Medicare would realize savings downstream as physicians change their practice patterns.

Chairman **Stark**. But you are also testifying that you would prefer to see us take the capitation approach as even a better way, having not only the restrictions but the incentives to save?

Ms. **Mitchell**. Well, the more global the package of services, the greater the potential for savings. And capitation could be seen as the ultimate package. Capitation within an HMO setting, for example, does have the advantage that you are bundling both hospital and physician services together. From an economist's standpoint, that is certainly much more desirable.

Chairman **Stark**. I happen to think your testimony is right on target, so I wish I could lay a much greater record down here, but I do not suppose it will make much difference——

Ms. **Mitchell**. I am sorry? I——

Chairman **Stark**. I say I happen to agree with your testimony, and I think I share many of the concerns that your testimony brings to light.

I am not sure that just setting a group of fees is going to be the best thing for the taxpayers or the beneficiaries, and I appreciate your providing us with this information. I look forward to having you submit more of your suggestions to us because I am having trouble figuring out how we are going to continue just paying fees and letting the fox in the hen house, and how we are going to save any money.

That troubles me, it just isn't human nature for someone who is making money charging fees to run a system that is going to reduce their income. I do not know of any profession where that happens, and so I thank you very much.

Ms. **Mitchell**. Thank you.

Chairman **Stark**. Our final witness is Dr. James Todd, the senior deputy executive vice president of the American Medical Association. Welcome to the committee, Dr. Todd. We have your prepared testimony, and it will appear in the record in its entirety. Please feel free to add to it, amplify it, or summarize it in any way you are comfortable.

STATEMENT OF JAMES S. TODD, M.D., SENIOR DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART AND JANET HORAN

Dr. Todd. Thank you, Mr. Chairman. I am Jim Todd, the senior deputy executive vice president of the American Medical Association, and with me are Mr. Bruce Blehart and Ms. Janet Horan of the Association's Department of Federal Legislation.

We do appreciate this opportunity to appear again before this committee to discuss Medicare part B premium increases. Unfortunately, obvious circumstances such as you already have discussed, including the new catastrophic legislation, make it reasonable to expect a premium increase in 1989. Also, it is reasonable to believe that there will be continued annual increases in the light of demographic and other factors that have increased the demand for care.

The AMA believes that all premium increases deserve very close examination. Briefly, since they are detailed in our formal statement, I will only highlight some of the reasons for the increased use of part B services, and therefore premium increases.

We believe they relate to the diversity of the Medicare population, and reflect long-term trends in demographics, changes in technology, patient demand, system modification, improved access, and, indeed, inflation.

Last year, we requested that the Health Care Financing Administration identify specifically the causes for the increase of services purchased with part B dollars. To date, we have received no formal response that answers any specific questions raised in our inquiry.

A detailed analysis of the trends pushing premium increases is set forth in our statement for the record.

Mr. Chairman, the American Medical Association agrees with your assessment that the volume of services provided is an important aspect of premium increases that must be addressed.

Volume certainly must be viewed as a key element in the growth of Part B expenditures, given the fact that program expenditures have continued to increase in this decade at a time when physicians have taken part in a voluntary fee freeze, have been subjected to Congressionally imposed Medicare reimbursement cuts and limits as well as fee freezes, and are now subjected to Medicare price controls. Therefore factors other than unit costs are at work in causing premium increases.

To determine whether physician gaming would take place after the freeze on physician reimbursement was enacted in 1984, Congress called for a study. This study was due July 1, 1985 and has not been completed.

However, a similar study, by Dr. Peter McMenamin for the Health and Human Services Assistant Secretary for Planning and Education, indicates that the vast majority of physicians have been scrupulous in their dealings with the Medicare program.

The draft report indicates that the increase in intensity does not reflect fraudulent or improper changes in billing practices. The report also examined the issue of visit unbundling, and concludes there was no volume increase with respect to follow-up visits. Dr. McMenamin also points out that an increase in the volume of services provided by physicians is consistent with an increased demand for services on the part of patients.

In Dr. Janet Mitchell's testimony previously this year before the Physician Payment Reform Commission, she pointed out that the total number of physician visits did not increase, but the setting for these visits did shift with an increase towards office visits.

Dr. Mitchell concluded that with earlier hospital discharges, office visits have become more complicated and more intensive. And she also included the following statement in today's that testimony, and I quote: "It is important to note that this does not necessarily imply fraudulent billing practices on the part of physicians; Real casemix changes resulting from PPS, as well as the ambiguous nature of the codes themselves undoubtedly are important factors."

Even so, it cannot be ignored that there is an increased patient demand for physician services. Medicare beneficiaries are older, they have more infirmities, and they are now facing lower financial liability because of increased assignment rates, decreased beneficiaries co-payments in real dollars, and increased Medigap coverage for physician services. Lower real costs do indeed increase demand, and less than 20 percent of Medicare beneficiaries are dependent solely on Medicare to reduce the financial impact of an illness.

Out-of-pocket costs in proportion to total costs have fallen since 1985, as a result of more physicians accepting Medicare assignment. Physicians do accept their responsibilities to recognize the economic as well as the health needs of their patients. While 37.3 percent of physicians are participating physicians in the Medicare program, 92.4 percent of all physicians in this country who saw Medicare patients have accepted assignment, and over 78 percent of the charges for physician services were assigned in the most recent accounting period.

Mr. Chairman, we recognize, as do you, that this present trend cannot be allowed to continue without some modification, and we want to leave you and the committee with an accurate picture of where the American Medical Association and organized medicine stands in this fight to get a grip on the underlying issue, and that is the growth of volume of services.

While we never want to see a situation where a patient is denied access to beneficial care, we do recognize a responsibility to assure that the care provided does benefit the patient.

This fact is a major reason for the AMA's increased involvement in scientific studies such as the Rand study, to identify and reduce utilization of ineffective medical procedures.

The American Medical Association is also in the forefront of those examining the quality and scope of medical care. In addition to the routine publication of information on subjects ranging from technology assessment to utilization of services, the AMA's Office of Quality is undertaking activity to aggressively promote organized and systematic quality assurance and quality assessment activities that will help protect and improve the quality of care provided to our patients, including Medicare beneficiaries.

In accepting the challenge to rationalize the changing healthcare system, and continue to maintain and improve the quality of care, the AMA is developing an agenda to: pursue the reduction of patient demand for inappropriate services; bring better focus to help patients understand the risk-benefit considerations in the receipt of health care; establish quality parameters, not standards that assume that every patient and every physician is the idealized average, but parameters that should be maintained for various procedures and services; and establish better methods of documenting that the care provided is necessary and appropriate.

Mr. Chairman, the American Medical Association will be pleased to work with you and the committee in seeing that Medicare beneficiaries continue to receive quality health and medical care services, and that public dollars are spent wisely.

Whether public expenditures are for the purchase of defense equipment, food or housing under welfare programs, or medical services under Medicare, the American public has the right to expect accountability. And such accountability necessitates the availability of all of the facts, and we will try and work with you and the Administration, and others, to develop these facts and information and try to use them wisely.

We will be pleased to respond to any questions that the committee may have.

[The statement and attachment of Dr. Todd follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means

United States House of Representatives

Presented by

James S. Todd, M.D.

RE: Medicare Part B Premium for 1989

September 29, 1988

Mr. Chairman and Members of the Committee:

My name is James S. Todd, M.D., and I am Senior Deputy Executive Vice President of the American Medical Association. With me are Bruce Blehart and Janet Horan of the Association's Department of Federal Legislation.

The AMA appreciates this opportunity to appear again before the Committee to discuss Medicare Part B premium increases. Unfortunately, obvious circumstances make it reasonable to expect an increase for 1989. Annual increases can be expected in light of demographic and other factors that have increased the demand for care. Moreover, this year the Medicare Catastrophic Coverage Act of 1988 alone will require an additional $4.00 in the Part B premium for 1989, with further statutorily required increases scheduled for future years.

The AMA believes that all premium increases deserve close examination. Mr. Chairman, we agree with your assessment that the volume of services provided is an important aspect of premium increase that must be addressed. Volume certainly must be viewed as a key element in the growth of Part B expenditures given the fact that program expenditures have continued to increase in this decade at a time when physicians have taken part in a voluntary fee freeze, been subjected to Congressionally-imposed Medicare reimbursement cuts and fee freezes, and are now subjected to Medicare price controls known as the Maximum Allowable Actual Charge program (MAAC). (No other sector of the economy and no other government program have been subjected to so many controls. Fee freezes may result in one-time savings but do not address the reasons for program cost escalation.) This indicates that factors other than unit costs are at work in causing premium increases.

We believe that Part B premium increases directly related to the provision of physician services can be attributed to several factors: the changing nature of medical care, changes in Part A coverage, technological changes, population variables, an increasing proportion of enrollees exceeding their deductibles, lower real beneficiary cost, and improved access. We will discuss each of these factors in greater detail.

The Changing Nature of Medical Care Systems - Practice Location

As a result of Medicare's hospital Prospective Pricing System (PPS), technological advances, and other factors, the nature of the medical care system has changed. Medical care has increasingly moved out of the hospital with physicians providing a more intensive level of care in their offices, ambulatory surgery centers and in other non-hospital settings.

By way of example, our data show that the mean length of stay for a hospitalized patient in 1982 (prior to the PPS) was approximately eleven days, and last year the mean length of stay was down to about seven days. One result of shorter hospital stays is that the patient will utilize more Part B covered ancillary services and require more intensive physician involvement. While the hospital and its personnel who routinely would have provided inpatient care (Part A) will be relieved of responsibility on discharge, the need for patient care does not disappear and physician responsibility (Part B) increases.

With physicians strongly discouraged from admitting patients to the acute care hospital setting when services may be provided at a less intensive level, and especially with the increasing age of the Medicare population and the rapid and appropriate growth of ambulatory surgery, it is reasonable that Part B expenditures will reflect an increase in both care provided and intensity of that care as more services are transferred from the hospital.

We need to examine carefully the extent to which savings accruing to the Part A side of Medicare may offset expenses added to the Part B side.

- According to HCFA, from 1974 to 1983 reimbursements for hospital outpatient services to Medicare beneficiaries increased from $0.3 billion to $2.7 billion, an average annual rate of growth of 26 percent.

- For all Medicare reimbursements during this period, the average annual rate of growth was 20 percent. HCFA further found that from 1983 through 1985, reflecting the first 2 full years of the Medicare prospective payment system, hospital outpatient services reimbursements rose from $2.7 billion to $4.1 billion, an average annual rate of growth of about 23 percent. For all Medicare expenditures, the average annual growth rate slowed to an estimated 12 percent.

Clearly, this growth in outpatient services will continue to result in increased Part B expenditures.

Induced Demand

When the freeze on physician reimbursement was incorporated into the Deficit Reduction Act of 1984, Congress called for a study to analyze whether physician "gaming" would take place. While this study, due July 1, 1985, has not been completed, preliminary results of a similar study by Peter D. McMenamin, Ph.D., for the HHS Assistant Secretary for Planning and Evaluation, point out that the vast majority of physicians have been scrupulous in their dealings with the Medicare program. The draft report indicates that the increase in intensity does not reflect fraudulent or improper changes in billing practices. Dr. McMenamin also examined the issue of visit "unbundling" and concludes that there was no volume response with respect to follow-up visits.

To date, we have seen no evidence to indicate that the increase in expenditures for physician services has been caused by physicians. To the contrary, Dr. McMenamin's analysis points out a number of plausible reasons, including:

- The growth and aging of the Medicare population;

- Maintaining the deductible at the level set in 1981;

- Assignment being more readily accepted;

- Charges having been held down; and

- Costs of office visits declining in relative price.

Dr. McMenamin aptly points out that an increase in the volume of services provided by physicians is consistent with an increased demand for services on the part of patients.

Dr. Janet Mitchell's testimony this year before the Physician Payment Review Commission (PPRC) indicates that in 1983 the average Medicare beneficiary made 2.9 office visits and 2.9 hospital visits. By 1986, the number of office visits had increased to 3.5 and hospital visits fell to 2.3. Although the total number of visits did not increase, the setting for these visits did shift with an increase toward office visits. From this, Dr. Mitchell concluded that with earlier hospital discharges, office visits have become more complicated and more frequent.

Technological Change

Technological change is another factor leading to Part B premium increases. Medical advances have increased the availability and safety of established and new types of care to Medicare beneficiaries, especially in the outpatient setting. Patient awareness of these advances and new procedures have increased demand for physician services. In Dr. Mitchell's PPRC testimony, she cited an increase in spending due to technological advances occurring, for example, in ophthalmology (cataract surgery), joint replacements, diagnostic surgery, cardiac catheterization, colonoscopies, organ transplants, Magnetic Resonance Imaging, and mammograms. This expanded availability of advanced medical technologies to our patients has brought with it substantial benefits that are evidenced through improved health status and quality of life.

Population Trends

A third factor to be considered in understanding Part B premium increases relates to patient demographics. As people grow older, they have more illnesses and require more medical services. HCFA data also clearly indicates that new beneficiaries are also using more services than prior groups of 65-70 year old patients. The Medicare actuaries estimate nationally that the proportion of beneficiaries receiving reimbursed physician services increased from 67% to 76% between 1981 and 1986. This increased demand alone accounts for a significant portion of the increase in Part B expenditures.

Furthermore, the actuaries have found that in 1960 only 5.6% of the aged were 85 and older; by 1990 this group will be 9% of the elderly and is projected to rise to 13% by the year 2000. This increase in the number of older persons has direct implications for future volume and expenditures for health services.

Beneficiaries Exceeding Deductibles

A fourth factor to consider in analyzing a Part B premium increase is the increasing proportion of enrollees exceeding their deductibles. From 1982 to 1986, the proportion of enrollees who exceeded their deductibles rose from 67.9 to 77.8%. (The Part B deductible has been held relatively constant by the Congress.)

Reduced Real Costs of Services

A fifth factor, closely related to this increase in enrollees exceeding their deductibles, is the decrease to beneficiaries of the real cost for medical services. Patients who are Medicare beneficiaries face lower financial liability because of increased assignment rates, decreased beneficiary copayments in real dollars and increased supplemental coverage ("Medigap") for physician services. Lower real costs increase demand. HCFA has reported that 70% of Medicare beneficiaries have private Medicare supplemental insurance and 13% are Medicaid eligible. Less than 20% of Medicare beneficiaries are dependent solely on Medicare to reduce the financial impact of an illness. HCFA further finds that, even for beneficiaries who are dependent upon only Medicare to finance their health care costs, out-of-pocket costs in proportion to total costs have fallen since 1985 as a result of more physicians accepting Medicare assignment. Between 1980 and the first quarter of 1988, the assignment rate has increased from 51.5% to 75.6% of all Medicare claims. Physicians accept their responsibility to recognize the economic as well as health needs of their patients: while 37.3% of physicians are participating, 92.4% of physicians who saw Medicare patients accept assignment; and over 78% of charges for physician services were assigned in the most recent accounting period. According to HCFA, and we agree, this may have stimulated an increase in services demanded.

Improved Access

A further factor to be considered in assessing the cause of a Part B premium increase is improved access to care and broader diffusion of new technologies. The increase in the use of physician services represents expanded access to care that the Medicare program holds out to the elderly, public policies have reinforced, the beneficiaries have come to expect, and physicians continue to provide. In fact, physicians have provided this expanded level of care with virtually no increase in reimbursement levels between 1983 and 1987. However, the increase in program expenditures illustrates that improvements in beneficiary access are not without cost.

Conclusion

Increases in the Part B premium are attributable directly to Medicare beneficiaries receiving necessary and valuable services for their well being. Reasons for increases in Part B services, and therefore premium increases, are diverse and reflect long-term trends in demographics, technology changes, demand, system modifications, improved access, and inflation. Last year we requested that HCFA identify specifically the causes for the increase of services purchased with the Part B dollars. To date we have received no formal response that answers the specific questions raised in our inquiry. (A copy of our letter to HCFA is attached.)

This Committee is to be commended for this hearing aimed at identifying facts for the public. Unfortunately, the same public that was told one year ago that physicians were the root cause of the premium increase is unlikely ever to be presented with a clear statement of the complex factors that have caused the growing expenses of Part B of Medicare. Such misinformation needs to be quashed as it has the doubly unfortunate aspect of breeding mistrust between patients and their physicians.

The American Medical Association is in the forefront of those examining the quality and scope of medical care. In addition to the routine publication of information on subjects ranging from technology assessment to utilization of services, the AMA's Office of Quality is undertaking activity that will aggressively promote organized and systematic quality assessment and quality assurance activities to help protect and improve the quality of care provided our patients, including Medicare beneficiaries.

Mr. Chairman, we want to leave you and the Committee with an accurate picture of where the AMA and organized medicine stands in the fight to get a grip on the underlying issue inherent in any examination of increased program premiums: the growth of the volume of services. While we never want to see a situation where a patient is denied access to beneficial care, we do recognize a need to assure that the care provided benefits the patient. This fact is a major reason for the AMA's involvement in scientific studies, such as the Rand study, to identify and reduce utilization of ineffective medical procedures.

In accepting the challenge to rationalize the changing health care system and continue to maintain and improve the quality of care, the AMA is developing an agenda to: pursue the reduction of patient demand for inappropriate services; bring better focus to help patients understand the risk/benefit considerations in the receipt of health care; establish quality parameters (not standards that assume that every patient is the idealized average) that should be maintained for various procedures and services; and establish better methods of assuring that the care provided is necessary and appropriate.

Mr. Chairman, the AMA will be pleased to work with you and the Committee in seeing that Medicare beneficiaries continue to receive quality health and medical care services and that public dollars are spent wisely. Whether public expenditures are for the purchase of defense equipment, food or housing under welfare programs, or medical services under Medicare, the public has the right to expect accountability. Such accountability necessitates the availability of all of the facts, and we also will work with the Administration and others when that information, as we requested, is available from HCFA.

We will be pleased to respond to any questions from the Committee.

2740s

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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

September 18, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201

Dear Dr. Roper:

First, let me again express my appreciation for the opportunity to meet with you to discuss the increase in Part B expenditures. The on-going dialogue between our organizations is essential in adequately addressing the underlying causes necessitating the proposed premium increase and responding to the high level of Congressional and media interest in this issue. Unfortunately, some critics, in a rush to judgment, have unfairly laid the blame on physicians for the increase in total Part B expenditures without any documentation of the root causes. Congress and the Administration must determine the underlying factors which explain the increase in Part B spending before even beginning to entertain legislative or regulatory options.

As you know, the Health Subcommittee of the House Ways and Means Committee chaired by Representative Stark will be holding a hearing on September 30 to look into this matter. The AMA has been invited by Chairman Stark to testify at this hearing and we intend to participate. In order for us to develop our testimony, it will be helpful for us to obtain information that is available only from the Health Care Financing Administration.

This letter is to request your immediate assistance in obtaining answers to the following questions so that we will be able to address these important issues:

1. It has been reported that Glen Hackbarth indicated that one reason for the 38% increase in premiums related to a decision by the administration to "spend down some of the contingency reserve." (New York Times, September 15, 1987) What portion of the 38% increase in the proposed premium can be attributed to the catch-up necessary because of the trust fund spend-down? How was it that the premium could be held down in light of the statutory requirement for the Part B premium to cover 25% of program costs?

2. What portion of any increase can be attributed to shifts in services from Part A to Part B? Specifically, can any of the increase be attributed to services that are now provided on an outpatient basis that would previously have been provided under Part A, such as services attributable to increased use of improved outpatient technology, incentives for outpatient surgery, reduced lengths of stays due to DRG implementation, and utilization controls such as preadmission reviews that have shifted procedures to the outpatient setting? Can any of the increase be attributed to outpatient work-ups prior to hospitalization? Ancillary service costs? Technical components?

3. What percentage of the increases can be attributed to general inflation? Increased patient population? Increased number of eligibles filing claims? Increased intensity due to shorter hospital lengths of stay? Increased intensity due to the growth of the over age 75 population.

4. Could you identify the increases by practitioner classification and other service components? For example, how much of the increase is attributed to "physicians" under Section 1861 (r)(1) (M.D. and D.O.) and each of the other practitioners identified in 1861 (r) (podiatrists, chiropractors, optometrists, and dentists)? What portion of the increase is attributable to non-physicians services such as durable medical equipment and other part B services (including home health services provided by a home health agency, rural health clinic services, etc.)?

5. Press reports have also indicated that a significant portion of the increase can be attributed to "increases in fees." Previous to the period in question, Medicare reimbursement was strictly controlled through freezes on prevailing and customary charges and limits on updates in the MEI. Also, fees of non-participating physicians were frozen at the April - June, 1984 levels. Physician reimbursement and fees are still rigorously controlled. Is it your view that the larger-than-expected increases are caused by physician fee increases? If so, we would be interested in knowing to what extent and the specific fee increases that have caused the reported increase?

6. Is there any impact caused by the prompt payment provisions? If so, what percentage relates to increased costs due to prompt payment and what percentage relates to interest paid on overdue claims?

7. Are administrative costs factored into this increase? If so, what percentage of the increase can be attributed to carrier costs, including increased carrier responsibilities, the participating physician program, providing directories of participating physicians, processing of MAAC information and surveillance and monitoring of the MAAC program?

8. The press has indicated that part of the increase relates to increased utilization of services by Part B beneficiaries. Is the Department aware of specific instances of inappropriate utilization patterns or upcoding under Part B?

9. In that controls on physician fees have held down the costs of these services to levels lower than they would have been without the fee controls, how much increased utilization can be attributed to increased demand induced by lower real costs?

10. At the time of implementation, it was projected that implementation of the HMO/CMP option could actually cost the program more money. Can any of this increase be attributed to increased use of the Medicare HMO/CMP option?

11. What percentage of the increase can be attributed to charges submitted by participating physicians? Non-participating physicians?

12. What percentage of the increase can be attributed to increased reimbursement levels to participating physicians?

13. Can any of the increase be attributed to the availability of new or expanded benefits such as the expanded coverage for vision care?

14. Can any of the increase be attributed to payments made during the period in question that were, for whatever reason, deferred from an earlier period?

15. What portion of the increase can be attributable to services provided in hospital outpatient departments? Ambulatory surgical centers?

I recognize that these are complex questions requiring detailed answers. Such information will enable us to address more fully the issues surrounding the announced increases.

I look forward to your prompt reply to this request. In light of the short time available to us, please feel free to have your staff contact our Washington office with the information as soon as any of the information is available.

Sincerely,

James H. Sammons M.D.

James H. Sammons, M.D.

JHS/dl

Chairman **Stark**. Mr. Moody.

Mr. **Moody**. Thank you, Mr. Chairman.

Dr. Todd, this is a very interesting and helpful summary. How do you respond to the testimony—I assume you heard it and probably read it as well—of Dr. Mitchell, who preceded you, whose testimony really varies quite a bit in a number of ways.

Would you comment on her testimony?

Dr. **Todd**. Well, I think if you look in our prepared testimony, the full text of it, on the bottom of page 4, the beginning of page 5, you see that Dr. Mitchell's full testimony and in testimony before the PPRC earlier this year, she indicated that the total number of visits between patients and physicians over the period of time that she studied did not change. The location of those visits changed.

Mr. **Moody**. Right.

Dr. **Todd**. Under prospective pricing, patients were encouraged to leave the hospital earlier, less well recovered, and this therefore required physician visits that ordinarily would have taken place in the hospital, but now take place in the physician's office.

In addition, with more procedures being done on an outpatient basis, more equipment and personnel are necessary in physicians' offices in order to be able to accomplish procedure that once were done, perhaps as hospital inpatients or outpatients using hospital facilities, more care is now being done in physicians' offices, and that comes under part B.

It would be interesting to compare the difference in the swing in the amount of expenditures in part A that have been shifted to part B because of prospective pricing.

Mr. **Moody**. But the interesting thing was that while total number of visits stayed the same, spending on those visits increased 14 percent in just the 22-month period in question.

She said the reason for this was a relabeling of the visit codes from simpler to more complex and more expensive ones.

Dr. **Todd**. And let me remind you that she clearly said there was no evidence of any physician fraudulent behavior.

Mr. **Moody**. No, no. That is right.

Dr. **Todd**. Her conclusions you would anticipate to be exactly on target. If I, as a surgeon, send a patient home from the hospital on the third post-operative day, still with a drain in place, an unhealed wound, subsiding obstruction of a bile duct, or any number of things, the intensity of the followup office visit is indeed going to be greater than if the patient had spent 8 days in the hospital. The drain was out, the wound was healed, and the lab work had been done in the hospital.

Mr. **Moody**. Right. How do you explain the fact that the specialties increased, however, by such dramatically different numbers? General and family practitioners by 13 percent in this same period; internists, 17; general surgeons, 9.

But dermatologists, cardiologists, gastroenterologists, ophthalmologists, and thoracic surgeons had truly dramatic increases.

Would you ascribe all that to the very phenomenon you just described, the shift from part A to part B?

Dr. **Todd**. No, not all of it. Certainly some of it is a consequence of new technology being available. It has only been in the recent few years, for example, that it has been considered safe to remove a cataract in an outpatient setting, or in an ambulatory surgical setting.

I think there are a whole series of reasons why this has happened. We have talked about them in our prepared statement, but it is a combination of improved technology and the shifting from part A to part B, and the fact that appropriate or not, people in this country place a great, heavy emphasis on technology.

People who have cataracts and blurry vision now know that correcting the problem is a 1 day procedure and they want to see better, and they have been made to see better through this increased surgical activity.

Mr. MOODY. As this new technology comes on line, however—in the computer field, for example—we see the prices drop. The price of computer-related equipment today compared to what it was a few years earlier has dropped very dramatically. That's true for VCR's, all sorts of new technology. But in medicine, the new technology does not seem to drop the price. The price seems to, if anything, increase.

Dr. TODD. Well, I would give two answers to that, Mr. Moody. First of all, some of those who seem to charge the highest prices are also those who are working on the frontier of medicine and spend a considerable amount of uncompensated time in the laboratory, researching and developing new procedures that may be even more beneficial than the ones they are currently using. But perhaps even more important than that is that the product that some of these physicians provide and do not misunderstand me. I am not for a moment defending all of the prices that your committee is aware of—but perhaps more important is that the product the patient is receiving today is very different.

I began putting in cardiac pacemakers in 1976 or 1977. One wire, one little battery. Today, it is four or five different wires being placed in different areas of the heart, with a different kind of a battery. Procedures change; improvements are made; and the product is not necessarily the same as when it was first introduced.

Mr. MOODY. I will not hold you much longer. But, finally, your testimony on page 2 and also again on page 4 cites lower real beneficiary costs. I want to get back to this discussion we had with earlier witnesses; namely, the responsiveness of volume with respect to price.

I assume the AMA has looked at this because it is such a crucial question. What is your estimation on the price elasticity of demand, if you will, to use an economist term?

Dr. TODD. Well, we have looked at it, and we have relied on Dr. McMenamin's study perhaps more than our own, to suggest that there has not been an inappropriate increase in volume as a physician response to price freezes, at least in terms of frequency of visits and location of visits, or inappropriate upcoding. I do not think anyone has any objective evidence that would allow you to draw a conclusion one way or another as to whether physicians are increasing volume to make more money or whether they are increasing volume because they are seeing sicker patients, or patients are demanding or interested in more care.

You have to bear in mind that——

Mr. Moody. But is price a determining factor, either on the side of the beneficiary or on the side of the physician, in terms of volume outcomes?

Dr. Todd. It seems to me it would be naive to say it was not in certain circumstances. On the other hand, when most physicians undertake the care of a patient, they may not be even sure of the source of the payment, the level of the payment, or even if they will be paid. I am not at all sure that you can equate the two completely.

Mr. Moody. When I ask that question, I am referring to both the patient's demand for services with respect to price as well as the physician's supply of services with respect to price.

Dr. Todd. From the patient's point of view, they are so well protected from price sensitivity that I really do not believe that you can reach a conclusion that patients are price sensitive because of the Medigap coverage and other factors set out in our statement.

Mr. Moody. Well, the reason I ask is because you cite it as one of the major factors, and I wonder if you had quantified that or what have you.

Dr. Todd. No.

Mr. Moody. One final question, back for a moment to this part A to part B switch or displacement effect. In a hospital setting, part A, the doctor sees the patient virtually every day; whereas, in a part B setting, they do obviously much less frequently. Therefore, shouldn't moving location of service from part A to part B actually bring down the cost because of much less frequent patient-doctor contact?

Dr. Todd. No, because the intensity of the office visit is greater. You are now relying on the physician's facilities, personnel, and equipment; whereas, if the patient were in the hospital, the physician would be using the hospital's materiel and whatnot. So, no, I do not think the visit post-op for the earlier discharge from the hospital should necessarily be considered less expensive than the visit in the hospital.

Mr. Moody. But the payment in the hospital is 40 or 50 percent higher than the payment in the outpatient setting. Or am I wrong on that?

Dr. Todd. I am not aware of that.

Mr. Moody. If that is true, that should have the opposite effect. OK. Well, we can leave that to the future. I would appreciate any commentary later you would have by writing.

Thank you.

Dr. Todd. We will try and get it for you, sir.

Mr. Moody. Thank you, Mr. Chairman.

[The following was subsequently received:]

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DIVISION OF LEGISLATIVE ACTIVITIES
ROSS N. RUBIN, J.D.
Director
DEPARTMENT OF FEDERAL LEGISLATION
BRUCE D. BLEHART, J.D.
Director
(645-4764)

October 10, 1988

The Honorable Jim Moody
1721 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Re: Physician Charges for Office and
Hospital Visits

Dear Congressman Moody:

This letter is in response to your request at the September 30 hearing of the Ways and Means Committee Subcommittee on Health for additional information on charge differentials for physician services for hospital and office visits. According to the AMA's 1987 Autumn survey of physicians (Socioeconomic Monitoring System, SMS), the mean physician fee for an office visit with an established patient was $32.77. The mean fee for a follow-up hospital visit was $35.90. The attached table provides a detailed analysis of physician fees for these services. The SMS program is fully documented in the AMA's Socioeconomic Characteristics of Medical Practice, 1987. Please contact me if you would like a copy.

I believe this information, which shows similar charges for the two services, is responsive to your request. If you have additional questions, I will be pleased to assist.

I am forwarding a copy of this letter to Chairman Stark for inclusion in the hearing record.

Very truly yours,

Bruce D. Blehart

4283p

cc: The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
1114 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

James S. Todd, M.D.

	1987 FEE FOLLOW-UP HOSPITAL VISIT (MEAN)	1987 FEE OFFICE VISIT ESTABLISHED PATIENT (MEAN)
ALL	35.90	32.77
BY SPECIALTY		
GP/FP	29.46	25.02
GEN INT MED	36.92	33.68
IM SUB SPECS	39.78	39.29
GEN SURG	35.33	29.24
SURG SUB SPECS	36.19	35.72
PEDIATRICS	26.15	29.68
OB/GYNE	40.35	38.39
RADIOLOGY	NA	NA
PSYCHIATRY	NA	NA
ANESTHESIOLOGY	NA	NA
PATHOLOGY	NA	NA
EMERGENCY MED	NA	NA
OTHER SPECS	41.12	34.57
CENSUS DIVISION		
NEW ENGLAND	34.86	36.97
MEDDLE ATLANTIC	44.36	38.30
EAST NORTH CENTRAL	30.97	28.06
WEST NORTH CENTRAL	29.04	27.82
SOUTH ATLANTIC	37.83	33.89
EAST SOUTH CENTRAL	29.45	27.32
WEST SOUTH CENTRAL	33.11	29.72
MOUNTAIN	31.90	31.72
PACIFIC	40.59	37.04
TYPE OF PRACTICE		
NON-SOLO	36.05	32.97
SOLO	35.73	32.56
LOCATION		
NONMETROPOLITAN	28.59	25.71
METRO ,1000000	33.38	31.37
METRO .=1000000	41.66	37.16
AGE		
36 YEARS	35.19	32.32
36-45 YEARS	35.63	32.60
46-55 YEARS	38.09	34.34
56-65 YEARS	34.66	32.52
65 YEARS	33.56	29.72
MASTERFILE-SEX		
MALE	35.86	32.68
FEMALE	36.34	33.76

Chairman **Stark**. Mr. Pickle?

Mr. **Pickle**. Doctor, in your testimony, you said that last year you had asked HCFA to specifically identify the causes for the increase in part B with reference to the charge that most of these increased costs were attributable to physician charges. And you stated in your testimony that you have not received a reply.

Is that current? Have they promised you a reply?

Dr. **Todd**. That is correct as of this date, sir.

Mr. **Pickle**. And you still have not received a response?

Mr. **Blehart**. Those questions were asked of HCFA three times within the last year. They were asked last September, again last December, and again in April of 1988, and there has been no formal reply to those questions.

Mr. **Pickle**. Next question is: You heard Dr. Roper make his statement before the committee today. I do not have that testimony in front of me at this moment, but did he make any reference that the charges were attributable to the physicians' overcharges?

Dr. **Todd**. No, sir.

Mr. **Pickle**. The question, then, was alleged by HCFA last year that these increases were due to physician charges, and yet they have not specified them or answered where and how. Is this true now?

Dr. **Todd**. That continues to be true. The impression was that the increase last year was the result of physician charges, and I guess the natural response was that it was increase in charges. But that was carefully controlled.

I think we all agree—Dr. Roper, Dr. Lee, and I certainly do—that a large element of the increase in expenditures has to do with volume. Where perhaps we do not agree is how much of that volume comes from what source, is it justified, and how can it be reduced.

Mr. **Pickle**. Volume may be a part of the question, and I guess the question, then, is: Is there a need for the services?

Dr. **Todd**. Well, this is something that we in our studies in quality assessment, quality assurance is in its infancy because it has only been relatively lately that physicians could do as much harm as they can do good in some of these areas——

Mr. **Pickle**. Well, Doctor, we have got a serious problem about charges in Medicare. In your statement, your testimony, did you make a proposal how we would control those charges?

Dr. **Todd**. Our testimony focused on how we would control volume. On the issue of charges, as you are well aware, we have been involved with the Harvard study in terms of supplying information and providing nominations to serve on the committees in their RBRUS study. We have committed ourselves to the completion of the Hsiao study that was released yesterday. The American Medical Association policy is that we should, indeed, have an indemnity fee schedule in place so that the payors, the patients and the providers will have a degree of predictability. And in addition to that, we want to look very carefully at the issue of appropriateness, necessity, place of service and the quality of that service.

As my testimony indicates, we are already beginning to work on developing parameters for appropriate care.

Mr. Pickle. Well, you say that we should have in place a physician fee schedule. My question is: Will you make such a proposal, and when? Because the committee is faced with serious decisions. Everybody says we are going to look into this question and make our report. HCFA still has not given us specific answers to your question, and you do not have a proposal.

I am to saying to you and to all the groups, this committee has got a problem. We are going to have to do something about it in the best judgment we have.

Now, I want to go to another step on it, just by way of current concerns. Have the physicians had a chance to look over the so-called Hsiao report?

Dr. Todd. We have seen only as much as you have in the public documents that are in the New England Journal yesterday, and the material provided at the two press conferences that were held.

Mr. Pickle. Do you have any reason to make a statement whether you are for it or against it, or what questions you would have about the report that has been published so far?

Dr. Todd. We can say, first of all, that we [illegible] in favor of a rationale fee schedule for physicians; and, secondly, like any other piece of research—this is economic research—it has to be peer reviewed to make sure that its methodology is correct. You as a committee will not adopt it without studying it; PPRC will not adopt it without studying it; and neither will the AMA. At this point, we will not either say yes or no until we have had a chance to look at it and determine its validity.

Mr. Pickle. Well, I think what Mr. Gradison is saying and Mr. Stark, in which I would join them, is that we need to have a positive statements proposal for all the groups what they would do. And most groups now have been a little bit less than positive about what they would recommend or they think should pass or what they would oppose.

I would hope that the various groups would help us come together, because if we do not, this committee, as usual, will make the decision. Congress will make it, and then everybody will be mad at the Congress. But if you keep finding it empty among the professional groups and administrative or executive branch, I guess then the ball bounces to us. So if there is any way you all could come together to reach an agreement and protect your professionalism, I think that is what we would want to do.

As one member, I do not want to let the public be scared that these costs are going up just because the physicians are gouging. I think that is a terribly unfair accusation to make against a profession. If there is proof that that is going on and they can specific it, then I think it ought to be brought out. But I do not think that HCFA or any other agency ought to just say this increase is particularly, is purely to do with physician charges, the inference being that they have done a lot of examinations that really were not necessary. And that is just an assumption on their part without being supported by fact.

Now, the volume has increased. The question is really why has it increased. And if we can ever get a handle on what caused it, maybe we can do something about it. But if we do not, we will be forced to do something about it. And next session is going to be the time to do it.

I just appeal for your cooperation and your help so that we can reach that decision.

Dr. **Todd**. Let me reassure you, Mr. Pickle, that we are prepared to work with this committee, with HCFA, and with any other group to try and bring the true facts out and to try and reach some reasonable conclusions as to how to deal with this.

We fully agree that a fee schedule is not going to solve the problem of volume. Volume has to be directly addressed and it should be addressed based on good, scientific information, risk-benefit analysis to the patient, and clear documents that the services that are provided are necessary and appropriate and of high quality.

Chairman **Stark**. Mr. Gradison?

Mr. **Gradison**. Thank you, Mr. Chairman.

Dr. Todd, I am delighted that you are here, and I appreciate that the issues before us and before you are very difficult. They are inherently difficult but, of course, they presumably are going to set some of your members against others. And as politicians we can understand how hard that is to deal with.

We try to avoid being in such situations and, in frankness, I am not sure in this case you are going to be able to do so.

I would like to begin by making a point which is irrational, but I think it is true, and that is that I think cost increases under part B are a problem that is going to have to be dealt with regardless of the reason. Even if every bit of that service is medically necessary, I think there is a going to be a push to do something because of the price tag.

I mean I don't say that to stir up controversy. I just think there is a problem out there, which is our budget problem, so we cast a ballot. And I was just trying to jot down some of the things we have talked about, some of the things we are either doing or talking about or experimenting with. I don't think this list is complete.

One is no change at all. Selective contacting, public bidding, withholds, a relative value scale, a more specific dealing with overpriced procedures. I am sure there are lots of other alternatives I just did not jot down.

But, as I look at this list, I don't think it makes sense to do all those at the same time. There must be some that make more sense than others. And I think that in doing this in the most sensible—if we are doing the irrational, we ought to do it in the most sensible way possible. I need your help to do so which leads me to one main question.

What process will you be setting up with the AMA to review Dr. Hsiao's work, and what is your time line? Can we look to have your recommendations at the same time that HCFA's recommendations are due, which I think is the first of July, I think that's right?

I am not trying to press you, but is that a realistic target?

Dr. **Todd**. Yes, I think it is, Congressman.

We have, and we will be happy to supply it for the record if you would like, a tentative time line that says as soon as we receive the document, be it 1,500 pages or 2,000 pages, then we at the AMA will reproduce it, Federal Express it to every national medical specialty society, to every State medical society, and to the metropolitan county medical societies for their review and comment.

We plan at least two meetings of the specialty society representatives and State society representatives, the first being in mid-November, to get their feedback. We will prepare a Board of Trustees report from the AMA which presumably will have recommendations, not necessarily definitive in the sense of saying it is good, bad or indifferent, but recommendations about how it can either be improved, modified, implemented, or any number of things.

That report will be presented to our house of delegates in early December, at their meeting in Dallas, where we hope to have a spirited, honest, straightforward discussion. The House of Delegates is composed of the entire Federation of Medicine, including specialists, as well as the State society people.

At the end of that meeting, we would hope to be able to come out with a direction that the AMA is going to take. My crystal ball is no clearer than yours, but we do have that time line.

I believe personally the House of Delegates will give to the Board of Trustees enough latitude——

Mr. PICKLE. When did you say that would be done?

Dr. TODD. That will be done in December, the first week in December in Dallas.

We think there are two important directions in order to do something about the costs and volume.

First is the fee schedule developed from a rational basis.

And second is to begin to develop the consensus on the parameters, call it whatever you want, on first those procedures where there is disagreement. Let's try and decide what is a reasonable range of appropriateness for procedure.

These two processes must go forward together. We are working on them together, with one task force is looking at the Hsiao study; the other task force is looking at the development of quality parameters and methods of documenting it. And we would hope by the end of the year, or certainly by early next year, to have a better handle on how we are going to deal with the volume issue.

This is a long-winded answer to say, yes, I think the AMA will have not only additional input, but will be prepared to respond at the same time HCFA has to make its response to the Secretary.

Mr. GRADISON. Would this response, as you now anticipate it, include alternatives, if you don't like the Hsiao study in the end, or ways to modify it, the linkages or whatever, if you find defects in the methodology rather than just saying we don't like that?

Dr. TODD. I think it would be inappropriate, given the problems that we all recognize, for us to make an immediate statement that said we don't like the Hsiao study, throw it outside, start all over again and do something else.

I think that if we find significant defects, but find it basically to have some merit, then we will work to try and improve it. If, on the other hand, it proves to be totally unacceptable, impossible of implementation, I would be very disappointed if the American Medical Association did not have an alternative ready to place into that breach.

Mr. GRADISON. So would we. Thank you very much.

Thank you, Mr. Chairman.

Chairman **Stark**. Dr. Todd, are you familiar with Dr. Mitchell's testimony we heard just a moment ago?

Dr. **Todd**. Yes.

Chairman **Stark**. And do you concur with that?

Dr. **Todd**. Concur in what regard? She said——

Chairman **Stark**. Do you agree with her testimony?

Dr. **Todd**. Not in total, no, because I think some of her conclusions and analysis of the reasons why physicians upcoded are inappropriate.

Chairman **Stark**. Could you explain what you mean?

Dr. **Todd**. Looking at her example of patients going from a simple office visit to a more comprehensive or more intensive office visit, as I suggested to Mr. Moody, the reason for that, in our view this occurs not infrequently, is that the patient is sicker when they are seen in the doctor's office than they have been in the past.

We know that patients are sicker when they go out of hospitals than they have been in the past. They are coming out of the hospital sooner than they have before. While I don't like to use the phrase "quicker and sicker," I would submit they certainly come out of the hospital less well recovered, need more attention of a more intensive nature in the physician's office during the follow-up period.

Chairman **Stark**. So you are suggesting that you don't think doctors, and I would be the last one to suggest that this is fraudulent, but that doctors wouldn't pick instinctively?

Suppose I go to my internist and I complain about three things, and one of the three has a higher value. Wouldn't it be instinctive that you would check that and bill my insurance company for the higher value?

Dr. **Todd**. Well, I think two responses to that, Mr. Stark.

First of all, having been in practice for 22 years; having traveled around the country in recent years the AMA and seeing a lot of physicians, I find very few physicians who consciously try and sit down and figure out which procedure shall I do that is going to give me the greatest return.

In addition, the——

Chairman **Stark**. Have you ever been to one of those seminars for billing clerks that teaches them how to bill in their office? Do you ever read medical economics? My God, there is a whole industry that trains your colleagues on how to run their medical practices. Maybe you are not traveling in the right circle.

Dr. **Todd**. I think care and billing are complicated, just as reimbursement mechanisms are complicated today. Indeed, even the carrier in the State of New Jersey put on programs to demonstrate to physician office staff how to appropriately fill out the forms.

But, as I was saying, I do not believe that physicians' prime motivation in making choices as to how they will treat patients——

Chairman **Stark**. Treat and bill.

Dr. **Todd**. Beg your pardon?

Chairman **Stark**. They treat them the best way they know how, but when they have got a choice of what box to check in the billing, do you know many that always check the lowest price?

Dr. **Todd**. This is why we are in favor of a fee schedule that will make it perfectly clear what a physician will be paid.

Chairman STARK. So, other than that, you agree with Dr. Mitchell's testimony?

Dr. TODD. Well, in terms of the facts that she has presented, they are facts that have been documented by others. My disagreement would be with her suggestion as to how to solve the problem. That is, bundle everything together into a global fee. Presumably the money would be given to somebody to parcel out to the various players. We think that would be worse than the system we have now, probably not administrable.

Chairman STARK. And you all don't like capitation either, is that correct?

Dr. TODD. It is very difficult for physicians in general to be forced to make medical decisions in terms of a finite amount of money that is available.

For example, let's say that you had geographic capitation next year in an area, and gave the money to whomever to administer, and you had a catastrophe in that area, the dam broke, or a new epidemic broke out, or the money for organ transplants ran out. And then you begin to see migration of people across geographic areas. It is very difficult.

And, indeed, we at the American Medical Association would much prefer to make decisions based on a certain degree of medical consensus and certitude and what we call rationalizing the patient health care system to eliminate unnecessary and inappropriate services wherever they exist, to reduce the expectations of the public that says every time they go to a physician's office they have to receive some scrt of a medicine or a procedure.

If we can do that, we may find some very significant savings. If we can do it fast enough—and we understand your concern in that regard—we may all be able to work together to reach the same conclusion that we all want: affordable quality health care for all those who are sick.

Chairman STARK. But if I can get that at a lower cost through HMO's, I would be serving the taxpayers well by directing the Medicare beneficiaries to go there, wouldn't I?

Dr. TODD. Any incentive, be it fee for service, HMO, PPO, any economic incentive has its good and its bad points. And, yes, if we could find a way to document, and clearly document the quality of care given under these various scenarios, yes, if you could find a group willing to provide the same quality service at a lower price, of course you should use it.

Chairman STARK. It is one of the things that I am afraid we are going to have to get. We have a group of professionals who advise us in a variety of areas. It is obvious that we are not professionals.

In the hospital area, for instance, last year the hospital market basket was 5 percent and the physicians' market basket was estimated by a group of your peers and other people at about 3.2 percent, and the inflation rate of CPI was 4 percent. And we are informed that the increase in physicians' net income ran around 13 percent.

Now, I can make the judgment that that sounds high. It is higher than the average. And as Mr. Gradison indicated, given pressure to reduce it, I don't think it would be unreasonable for me to deal with HCFA or you or someone else, and say we have got to come closer to 5 percent and being reasonable people, let's split the difference. To start there, we'll give you 9 percent. How do you see us getting there?

Is AMA willing to say whatever plan you like we can plug into a model, and probably in a month or two get an idea what it would be? Are you willing to work with us toward that end?

I am much more concerned about letting you divvy it up and just letting us get to the point of saying within whatever reasonable comparisons we have, we cannot go so fast.

Is there anything in that structure that offends the sensibilities of the AMA?

Dr. TODD. Not at all. We are prepared at any time to look at any proposal to try and analyze it as dispassionately as possible. As an example, consider our review of the Hsiao study. We have hired outside disinterested economic experts to help advise us so that we will not appear either in reality or in perception to have a bias.

But I can assure you that any program that is put forward that is rational, that will not deny necessary care, and that will be equitable to all of the parties involved, is one that we will look at very carefully.

Chairman STARK. Doctor, you are getting away from the point here. That's your responsibility, the business of quality, I have really no way of judging that.

It is not an acceptable negotiating ploy because we have got to talk quality with reference to overutilization or unnecessary procedures. I'll do that with you. But then let's not talk price here. Let's give your colleagues the benefit of the doubt.

There are no second-rate physicians in this country. If there are, that is something you ought to worry about along with your people who deal with licensing and the rest. Congress can't do that. You don't want us to.

So all I am saying is that we could simplify the procedures a lot if you would help us and say you would be willing to deal with us in aggregate amounts. That would encourage us to let the physicians have much more independence in how they wanted to get there. If they would say, look, we will roll up our sleeves and we will just guarantee you we won't do anything that really jeopardizes quality, but we will do our damndest to try and cut this rate of increase in half.

Now, you are not going to triple the membership of the AMA selling them memberships on that basis. But I think that if you recognize that that is what we have to do, we could save a lot of time in future negotiations. I am not anticipating that you are going to go off and do anything very radical.

With the freeze, physicians' incomes went up so it did not hurt the doctors, and we got rid of it. I, as you know but won't give me credit, broke it. I thought the doctors were promised an increase.

Now, it just seems to me that we are faced with this. The hospitals have had to swallow something they don't like. I didn't invent the DRG system, and I think there is a lot of improvement that needs to be done. It has, however, held some of the cost down, and I think it has caused some real problems.

I think we are going to have to find a way to keep the aggregate cost of physician services down. And I am indifferent. I don't think we can be exclusive. There will be HMO's and there will be provider funds. They are going to come from the corporations, not us.

You are going to have more fights with Aetna and General Motors and Joe Califano and Chrysler than you are out of this committee. But I am saying that our concerns are really how to keep the aggregate costs down. Your concerns have to be the quality. You can't expect us to make those decisions.

By the same token, you can't game us with it. You can't say, well, if you cut the price, we'll cut the quality. Because, in my opinion, that is not negotiating in good faith. I don't think we will do that to the physicians, and I don't think they should do it to the taxpayers in return.

I, for one, am optimistic that the Hsiao study and your profession will allow some. Now, if we don't all have to come up to the level of ophthalmologists, maybe there's a chance we'll save a few dollars.

So I look forward to getting your response to the Hsiao report. Beyond that, what you would add to it, at least here's a mechanism where we can measure aggregate costs. Let's roll up our sleeves and negotiate. It might be quicker and more painless than most people think.

Thank you very much for being with us, and the committee is in recess.

[Whereupon, at 5:10 p.m., the hearing was adjourned.]

[Submissions for the record follows:]

CONGRESSMAN FRANK ANNUNZIO'S TESTIMONY ON INCREASES IN THE MEDICARE PART B PREMIUM GIVEN BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE WAYS AND MEANS COMMITTEE SEPTEMBER 29, 1988

MR. CHAIRMAN: I would like to take this opportunity to commend you on your efforts to control the rising cost of health care for the elderly, and I appreciate the opportunity to testify on behalf of my constituents who are deeply concerned about the continual large increases in the Medicare Part B premium.

During the last twelve years, we have seen a dramatic increase in this premium -- about 18 percent annually. Last year alone, the Medicare Part B premium increased by an unprecedented 38.5 percent. Although the increase for 1989 will be 12.5 percent, there will be an additional premium charge of $4.00 a month for catastrophic medical protection -- for a total cost of $31.90 a month for Medicare Part B.

As you are aware, a number of factors have caused these increases. Changes in Medicare Part A coverage have resulted in shorter hospital stays, thus shifting the cost of Medicare Part A to Part B. Also, rapid development and advancements in technology and treatment have increased testing and procedures, and more and more of our nation's population are living longer and are joining the ranks of senior citizens who are Medicare beneficiaries. More beneficiaries, of course, translates into rising costs for the Medicare program.

However, these cost increases can and must be brought under control. We cannot continue to pass them along to the elderly, who are the least able to afford them. A comprehensive approach is needed to curb these burdensome increases. In the short term, to provide some relief, we should link Medicare Part B premium increases -- including the new catastrophic insurance premium -- to cost-of-living increases in Social Security. Senior citizens, especially those on fixed income, have been hard hit by these Medicare premium increases, and it is deplorable that our elderly may be forced to forgo needed health care coverage because of their inability to afford it. We must prevent the creation of a two-tier health care system -- one for those who can afford quality care and one for those who cannot.

The challenge for our country is to provide quality health care which is accessible to all of our senior citizens. At the same time, hard choices need to be made to restrict the growth of expenditures in medical services. Instead of shifting costs, we must curtail them.

Mr. Chairman, again, I commend you for holding this important hearing on controlling increases in the Medicare Part B premium, and it is my hope that in the near future, Congress will take the necessary steps to halt these increases, with no loss in coverage or benefits for our elderly who depend and rely on the Federal government to insure their health care needs.

Thank you, Mr. Chairman.

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William S. Frankl, M.D.
Robert M. MacMillan, M.D.

October 3, 1988

Robert J. Leonard
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Mr. Leonard:

I am writing you this letter concerning the cost of Medicare Part B. I am writing you this letter as a very concerned physician who has spent his entire career in academic medicine and am presently responsible for the activities of a large department of medicine made up of over 300 physicians, all of whom are involved in the Medicare Part B issue. Although I cannot speak for all of them, I think that my views reflect the views of the majority.

I understand that the chairman of your committee, Representative Stark of California, has been quoted as saying that "the fundamental problem is that Medicare gives doctors a blank check. The more services they provide, the more they earn, whether or not the services are really needed." This clearly indicates that Representative Stark considers that physicians are venal and are scoundrels. It is obvious that his view of physicians is that of a money-grubbing group of unscrupulous, unethical people. Unfortunately, Representative Stark does not understand the realities of medical care in the United States at the present time.

Although there are some instances of Medicare abuse, there are indications of serious abuse of taxpayer money in many other areas including the political, business, and legal arenas as well. However, it would be unfair to point to anything but a minority of individuals in the legal, political, and business communities as placing monetary considerations above the public good and the same view should be had of physicians.

Representative Stark should understand that the reason for the burgeoning of services in the United States today is based on two very important considerations, neither of which is personal monetary gain:

1. Technology is exploding and we as physicians cannot in good conscience withhold these high technology advances from our Medicare

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patients. To do so would be to abrogate our Hippocratic oath and our intellectual honesty. I must also remind Representative Stark that new technology is expensive and that the biomedical corporations and the pharmaceutical industry do not provide us with free technology which we can pass on to our patients.

2. There is a malpractice crisis in the United States. Representative Stark should know that failure to provide our technology in the appropriate setting is tantamount to malpractice. Representative Stark should also know that there are billions and billions of dollars being expended each year by the legal system in the United States directed toward malpractice claims. Therefore, the physician today is placed literally between "a rock and a hard place". The government damns us for spending too much money and the lawyers sue us if we do not provide the services appropriately to our patients.

Yes, changes must be made in the health care system, but they should be made in a wise and understanding manner. The government should obtain the advice and the counsel of those of us who toil diligently "in the trenches" and who understand the realities of the crisis in medicine. It is obvious that the entire system must be reformed and that physicians should not be the "whipping boys" in a system which penalizes us for virtually anything we do.

I would very much like to obtain your response to this letter and that it be made part of the record of your deliberations in the Ways and Means Committee.

Sincerely yours,

William S. Frankl, M.D.

William S. Frankl, M.D.
Thomas J. Vischer Professor of Medicine
and Chairman, Department of Medicine
Hahnemann University

WSF:mdc

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

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STATEMENT OF
FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN OF
THE NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

SUBMITTED TO
THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

REGARDING
INCREASE IN THE MEDICARE PART B PREMIUM

SEPTEMBER 29, 1988

My name is James Roosevelt. As Chairman of the National Committee to Preserve Social Security and Medicare, I represent the organization's more than five million members and supporters, the majority of whom are seniors depending on Medicare for their health care coverage. Our members are deeply concerned about the continuing escalation of health care costs and how they eat away at their retirement income.

Next January, Medicare Part B premiums are expected to go up another 29 percent from $24.80 a month to $31.90 a month. This increase will cost Social Security beneficiaries $85.20 a year. While more than half of the increase is the result of the new catastrophic insurance legislation, this will be small consolation for those low and middle-income seniors who had difficulty accomodating last year's huge 38.5 percent increase. And the increase in the basic Part B premium is 50 percent higher than Congress anticipated only nine months ago when it passed legislation mandating that this year's premium cover 25 percent of program costs as well. Fortunately, under current law, increases in the old Part B premium will be capped at the COLA increase beginning in 1990.

The National Committee agrees with you, Mr. Chairman, concerning the need to get program costs under control and to stop passing on the exorbitant increases in program costs to the elderly or to the taxpayers. Unless Congress controls costs, seniors will continue to worry about Congress passing along the costs to them. We are also pleased with your commitment to controlling costs without risk to quality.

> **The National Committee assumes in good faith that Congress will not again extend the legislation requiring the premium to cover 25 percent of program costs any further. The National Commmittee also urges Congress to link increases in the new premium for catastrophic insurance to the COLA increase rather than increases in program costs. If the premium increase is capped at the rate of the COLA, Congress will have that much more incentive to contain costs by reforming physician payments rather than passing these increases on to the elderly or to the taxpayers.**
>
> **With the potential savings from physician payment reform, Congress could take some preliminary steps to ease the financing burden imposed on seniors by the new catastrophic health insurance financing to which many seniors strenuously object.**
>
> **Physician payment reform will also make it easier for Congress to eliminate physician charges above Medicare-approved fees by undercutting the AMA's argument that Medicare's approved fees are "unfair."**

Unless premium increases are brought under control, legislators are likely to face a growing senior revolt. Medicare Part B, one of the fastest growing federal programs, has increased about 18 percent a year between 1975 and 1986. While there is some indication that the rate of growth has decreased, inflation in the program is expected to continue to outrun the consumer cost-of-living index. This means that many seniors do not benefit from their COLA because Medicare takes it right back out of their benefit checks. This year alone, 190,000 beneficiaries did not receive any increase in their Social Security checks because the premium increase was as great or greater than their COLA. Next year, we are likely to see a similar number of beneficiaries without the benefit of their COLA.

Seniors need their COLA not only to pay for increases in Part B premiums, but also increases in medigap insurance and out-of-pocket medical expenses as well as non-medical expenses. It is time to stop the raid on Social Security income for older Americans, and the only way to do that is to keep Medicare Part B premium increases at the COLA level after next year. This cap should include the new premium added by the catastrophic law.

A National Committee member, Walter Huffman from Royal Oak, Michigan, described the raid on benefits this way: "I wonder if any members in Congress really understand what really is taking place in this country as to Social Security and Medicare. Of the big raise of 4.2% last January, they took $7.90 from each of my wife's and my checks which amounted to $15.80 - leaving a net raise of $31.00. Then they lowered the amount Medicare paid (thanks to Gramm-Rudman), thus raising the amount our insurance company had to pick up. So Blue Cross raised our premium $50 a month. So you see our $31 raise is now a loss of $19 a month." Another member from Florida put it this way: "I have not been able to completely retire, I work part time. For the past few years Medicare premiums have gone up and my pay has stayed the same. We cannot shoulder more increases in Medicare payments. I thought we had social insurance." This letter was written before the new catastrophic law was passed adding more to the premium.

Physician services account for about 75 percent of Medicare Part B expenditures, and are at the root of higher Part B program costs. While Congress should not ignore inflation in outpatient and other Part B services, physician expenses are, without question, where the real problem lies. According to the Health Care Financing Administration, Medicare physician spending is increasing faster than non-Medicare physician spending. Between 1980 and 1986, Medicare physician spending increased 60 percent more than non-Medicare physician spending. Furthermore, 60 percent of last year's premium increase was due to increases in doctor spending. Unfortunately, the 1988 Medicare catastrophic coverage law failed to address the problem of inflation.

The National Committee is encouraged by the work of the Physician Payment Review Commission and urges Congress to pass physician payment reform during the next Congress. A fair fee schedule that takes time, skills and training into account is both desirable, as well as a way to save Medicare dollars. The Congressional Budget Office estimates that physician payment reform could save the Medicare program between $23 and $27 billion over five years.

More Medicare services are being performed by specialized, expensive doctors at higher prices. The current fee-for-service concept of medical care begs for abuse of the Medicare program by some health care providers. The more times a physician asks a patient to come back, the more tests and services prescribed, the more Medicare pays doctors. Also, during the last 15 years there has been a substantial increase in specialists. Doctors with medical specialties have increased from 78.8 percent to 85.4 percent, leaving only 14.6 percent of doctors in general practice. This trend adds to inflation because specialists usually charge higher fees for their services. Additionally, the customary, prevailing and reasonable (CPR) charge system of reimbursing physicians for services is in itself contributing to inflation. It bases current reimbursement rates on doctors' price-setting the previous year, rather than what would be a fair charge for a particular service.

Too many doctors are charging entirely too much for their services. An Austin, Texas, member complains, "Although I normally have one doctor whom I have seen for several years, somehow when I was in the hospital, two more doctors became involved in my case. They may have performed some services for two or three days, but other times they simply walked through the room and said, 'How are you today?' They each charged $60 per visit.... At this rate, a doctor with 10 patients in the hospital could spend an hour visiting each patient about five minutes and make $600 an hour."

Physician reform should not be passed without mandating assignment. Physicians should receive a fair reimbursement for their services and beneficiaries should be able to depend on Medicare paying 80 percent of charges. Currently, doctors charge beneficiaries more than three billion dollars annually above what Medicare reimburses, because assignment is not mandatory. As Mr. Donald L. Batchelor of Citrus Heights, California, plainly puts it, "Now most of the working class have paid into Medicare thinking we pay 20% and Medicare pays 80%. Well this is bull. They pay around 60%. This should be changed. We paid and should receive."

Unlike the Part B premium increase, Congress cannot argue that it is unable to correct the problem of excessive doctor fees because it will increase the deficit. Mandatory assignment is budget neutral. The AMA argues that assignment will make it harder for seniors to get health care because doctors will refuse to take Medicare patients. Considering that, on average, physician income from Medicare is about 30 percent of their total income, it is unlikely that substantial numbers of doctors will pull out of the program. That is especially true if payment reform results in a fairer reimbursement system.

In January, when beneficiaries face the $7.10 increase in their monthly premium, Congress can point to the added coverage they will receive. The question is, however, will the 1.3 million estimated to be helped by the catastrophic law in 1989 be able to squelch the roar from that other 29 million who will only pay the extra premiums? Physician payment reform alone will not provide beneficiaries any immediate relief. Our five million members and other beneficiaries, however, need relief from doctor overcharges or a reduction in the financing burden from the catastrophic insurance law.

To recap, the National Committee urges Congress to allow the Medicare Part B premium including the new premium for catastrophic insurance to be linked to the COLA beginning in 1990; to pass physician payment reform including the elimination of doctor charges above Medicare-approved fees; and, finally, to use savings from physician payment reform to restructure the financing of the catastrophic coverage.

Thank you.

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